Harvey Agnew, M.D., Editor

THE CANADIAN HOSPITAL

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Obiter Dicta

Modern Methods in the Care of the Aged

UNDER this heading an interesting lecture was given to the Royal Institute of Public Health and Hygiene by Mr. L. Z. Cosin, F.R.C.S., medical superintendent of the Orsett Lodge Hospital near Grays, Essex. We are indebted to the Department of Health in Ontario for reprinting this valuable address in booklet form and distributing it to the medical profession.

In about four decades the population of Britain over 60 years of age has risen from 2,500,000 to nearly 6,500,000 and the Beveridge report anticipated that by 1971 there will be 9,500,000 pensionable people (men 65, women 60). As the mortality rate decreases, the morbidity incidence will rise. Moreover the supply of nurses is not keeping pace with the increasing demands.

Dr. Cosin would have a geriatric department in each main hospital. After thorough study and treatment as indicated, patients would be transferred to long stay annexes only when maximum improvement had been obtained. These should be of various types—for the frail ambulant, for the permanently bedfast, for the senile confusional states, and for those patients whose needs are largely food and shelter. Geriatric rehabilitation is hastened by group encouragement just as in the case of members of the armed forces. Occupational therapy, physical therapy and a cheerful environment are most helpful. "The most important factor in geriatric rehabilitation is the visible improvement of other patients similarly incapacitated." Rehabilitation efforts must commence on admission. The aim should be to restore independence through painless movement, not merely to overcome pain. Bedfastness should be countenanced with reluctance.

The most important specialists in a geriatric department are a general physician experienced in the treatment of aged patients and a psychiatrist. The addition of Vitamin B^1 (thiamin), B^2 (riboflavin), and nicotinic acid, to a good mixed diet will restore mental equilibrium in many senile confusional states. One should give a high protein diet with the above added. Prolonged bromism will often simulate a senile confusional state, as will also "that much abused therapeutic measure—confinement to bed" in cerebral arteriosclerosis.

The majority of old people are quite amenable to surgery, including local anaesthesia and ice anaesthesia. The present day technique of prostatectomy avoids the old-fashioned two-stage operation. The orthopaedic surgeon's chief contribution to geriatric surgery lies in the modern treatment of fractures of the upper end of the femur. The Terry helical spring, by which the limbs can be supported and exercised in canvas slings suspended from these springs, and the Orsett elastic back rest have proved most valuable. The use of physiotherapy aides at Orsett Lodge, working under the direction of the physiotherapist, has taken a tremendous load off the nursing staff. This stimulating booklet would warrant careful study.

Training in Hospital Housekeeping

AN idea that could well be adopted elsewhere has been developed at Overlook Hospital in Summit, N.J. This is a plan whereby on-the-job training is given to women desirous of becoming executive housekeepers. At the present time two "interns" are accepted at one time for a six-months program of training. During this period they are given a good grounding in all phases of housekeeping, including the management of personnel, job analysis, time studies, departmental relationships, and supplies. About three hours daily are spent in lectures given by the hospital housekeeper, Miss Frances Penfield, and the balance of the day is spent "on the floor". The women work six days a week from 8 a.m. to 4 p.m. and are provided with $25 a month and full maintenance. It is proposed to enlarge the course to six trainees, one being taken in each month.

The program has much to commend it. Miss Penfield has stressed that, with more trained personnel in the housekeeping field, nurses could be relieved of many routine assignments which would normally come under the housekeeping department. Mr. Arthur W. Smith, the administrator (formerly assistant at the Royal Victoria Hospital in Montreal), has well stated: "Hospitals need top flight persons in this position, for they set the pattern of operation in a hospital."

Blue Cross Effects Still Another Economy

THE Plan for Hospital Care in Ontario has decided to drop the recording of dependent children. This has been done for several reasons. More irritation and extra work for hospitals develops from the temporary rejection of admissions for children not recorded than through all other causes. This would be eliminated if hospitals merely had to verify that the child was under 18 years of age and was the child of the subscriber. It does not help subscriber relations, either, to be forced to remind them constantly that they must record their children. Fifty per cent of the telephone calls to the Records Division have to do with the adding of children.

It would also improve group leader relations. Much of the available time of the 13,000 group leaders is now spent on this detail and its elimination would provide the group leader with more time to devote to maintaining interest in Blue Cross and also minimize the detailed work.

There are some disadvantages that had to be considered. The Plan will be obliged to accept the hospital's verification that the child admitted is the offspring of the subscriber and is covered by the contract. For this reason it is imperative that the hospitals co-operate with the Plan by making sure that the parent is asked (a) Is this your child? and (b) What is his (her) age? The hospitals and the plans are in partnership and both parties would suffer if careless checking were to develop. Another disadvantage is that there will be no exact record of the number of children covered. Actually the ratio of children has remained almost constant over eight years of experience.

The cash saving should be sizeable. It is estimated that the savings in labour and supplies in the Hospital, Records, Tabulating, and Accounting Divisions of the Plan will exceed $16,000 per annum, not to mention the saving in furniture and general equipment. Cincinnati and Boston operate on this basis now and Buffalo, Rochester, Milwaukee, and Minnesota go even further with their complete "blanket" coverage by eliminating *all* records of dependents. Experience would seem to be satisfactory.

British Nurses Get Charter

THE Nurses' Bill introduced into the British House and, interestingly enough, welcomed by the House of Lords, will mark a new chapter in nursing in Great Britain. Of greatest interest to us here is the arrangement for relieving the hospital of the cost of nurse-training, a development long urged by leading nurses in this country. Funds for nurse-training will be provided from the Exchequer through the General Nursing Council. This Council is to be reconstituted to contain a stronger educational group, including three nominees of the Minister of Education and making it more representative of the registered nurses. Nurse-training committees are to be set up in the fourteen regional hospital areas in England and Wales. The administration of the schools of nursing passes from the hospitals to the regional nurse training committees which will also continue research on nurse education. The General Nursing Council will co-ordinate the thinking and activities of these regional committees.

Already a number of management committees have formed joint preliminary training schools and the experience of these groups will now be available. Apparently these preliminary training schools have been quite popular with young women. Interestingly enough, a writer in the June issue of *Hospital and Health Management*, in discussing the lack of departmental or cost accounting in Great Britain, states that when the new system of accounts of the Ministry of Health was published it merely used the old Revised Uniform System in a modified form. He regretted that it would still be impossible to ascertain the cost of a nursing department in a hospital. He strongly urged the method proposed by Capt. J. E. Stone which would provide accurate information on actual departmental costs.

Hospital Problems and the National Health Grants Program

F. W. Jackson, M.D., D.P.H.,
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THIS subject may suggest to you two lines of thought: (a) how the program of national health grants is helping to solve some of our hospital problems; and (b) to what extent the program might add to the already burdensome responsibilities now imposed on Canadian hospitals. I would like to discuss *both* aspects of this historic health investment to show that the great federal aid scheme will help hospitals, even if it also brings into sharp focus entirely new problems which may quite conceivably become real challenges.

Before proceeding to discuss the health grants in relation to hospitals, I would like to review briefly the whole national health program with certain specific references to the Maritime provinces.

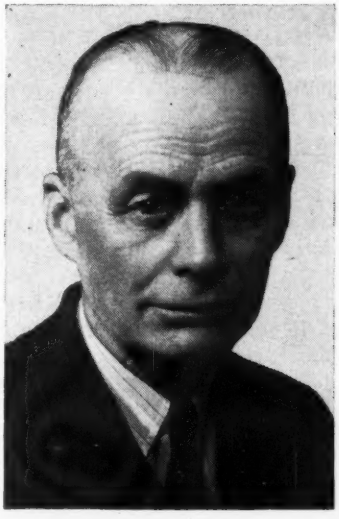
The very timetable of the grants program is interesting. The first announcement concerning it was made by the Rt. Hon. Mackenzie King on May 14, 1948. An amplification of the proposal was given by Mr. Paul Martin at the Canadian Public Health Association's Annual Meeting in Vancouver on May 18. The Dominion Council of Health, which is the advisory body to the Minister of National Health and Welfare and is composed in part of chief health officers of all the provinces, was called into extraordinary session at Ottawa on June 7 and 8 to discuss the administration of the grants, and to hear from the Minister the government's hopes for immediate and complete acceptance by all the provinces of this offer and financial backing. The relevant Orders-in-Council were prepared and received approval of Cabinet and Council on July 28. No time was lost in bringing benefits of the plan to the Canadian people.

From an address delivered at the Annual Meeting of the Maritime Hospital Association, June, 1949.

Orders-in-Council

I think I should explain here just why the Orders-in-Council covering the health grants are phrased precisely as they are, and why it is impossible to make any material changes in their wording and what it covers. Government procedure requires that there be formal legislative authority for the passing of an Order-in-Council and the wording of the legislation, therefore, strictly limits the scope of the Order.

The special legislation governing the national health grants is the Supply Bill, including the Estimates of the Department of National Health and Welfare. The wording of the individual grant items limits the scope of the various Orders-in-Council. To explain just what I am trying to convey, let us take as an example the hospital construction grant. The item in the Estimates in respect to it reads as follows:



F. W. Jackson, M.D.

Hospital Construction Grant, to assist the Provinces in the provision of adequate accommodation for hospital and health services; to be distributed on the basis of $1,000 per bed for active treatment beds, $1,500 per bed for chronic or convalescent beds, or, in the case of other health facilities, on an equivalent basis: Provinces to match or exceed Dominion contribution, which shall in no case exceed one-third of total cost.

You will see that the only way the money is authorized to be spent is on the basis of $1,000 or $1,500 per bed or bed equivalent. Before we could materially change the present terms of the Order-in-Council, it would be necessary to have a change made in the wording of the controlling item in the Estimates.

Projects Rapidly Approved

On August 25, the first project under the program was approved. Since that time, steadily day by day, projects have come forward at an increasing rate. By January and February of 1949, anywhere from 60 to 70 projects at a time were in process of going through. By the end of March, 1949, some 840 projects had been approved, involving a total outlay of more than $15,000,000. This was actually more than 51 per cent of the total amount of available funds.

When we consider the limited time the provinces had to make any plans, in the initial phase of the scheme, the great shortage of planning staff, and the necessity for them to make local arrangements for financing their projects before they could ask for reim-

bursement, we must admit that they did a marvellous job. Incidentally, a Maritime province, Prince Edward Island, has the distinction of having the highest percentage of money available to it allocated to its projects—namely, more than 91 per cent.

The money actually spent by the provinces amounted to $775,000,000 or 25.8 per cent of the total money available. Again Prince Edward Island headed the list, receiving more than 55 per cent of its total available funds. The three Maritime provinces together actually expended 36 per cent of their total grants.

Much Equipment Required

Only too well do we realize that personnel for the various fields of public health are conspicuous by their almost total absence. This fact, naturally, has seriously limited the provision of new services. Consequently, a considerable amount of the money expended during the first year was for equipment of various kinds. Even in that particular field all orders could not be filled before the end of the fiscal year. Altogether, some $750,000 worth of orders given by the provinces remained undelivered at the close of the year. However, it is expected that a supplementary estimate will be requested at the next session of Parliament to take care of these undelivered supplies. In any event, of course, the unexpended portion of the hospital construction grant will be reappropriated.

Training Program

Many excellent projects were started during the first seven months of the program's operation. Every province excelled in one or more fields. To my mind the most significant project that we have received so far is the Joint Training Program of the Maritime provinces at Dalhousie University. This provides for the training of various types of personnel required to staff the many new projects that will be developed under the grants program. Incidentally, when it gets fully into operation, this program should provide the necessary trained people to make the fullest use of the mental health grant, and we look to it to supply public health nurses in sufficient numbers to staff adequately, and ensure complete coverage of the Maritimes by, full-time health services. Such health service will be made possible by full utilization of the general public health grant provided for this purpose.

The cost of this particular cooperative measure, which includes the establishment of a new training program for public health nurses and for the reinforcement of the Department of Psychiatry and of the Maritime School of Social Work, is to be borne on a percentage basis by the three Maritime provinces, Prince Edward Island being assessed 8 per cent, New Brunswick 42 per cent, and Nova Scotia 50 per cent.

"In this advancing crusade all agencies, both public and voluntary, have their respective roles to play."

When the project is fully cooperative, it will mean a total budget of more than $20,000 for the School of Public Health Nursing and an increase in the budget for the Division of Psychiatry and the School of Social Work, starting at approximately $50,000 and increasing over a period of years to $57,000. All funds required for this training project will be obtained from the national health grants.

The project is to embrace efficient training of graduate physicians as psychiatrists, the training of clinical psychologists and of social workers in psychiatry, short courses for qualified physicians (particularly those in the public health field) and for nurses in all fields of public health endeavour, special courses for teachers and others engaged in youth training, and the regular course leading to the diploma in public health nursing to be made available under the new School of Public Health Nursing. With the arrangements being made for institution affiliation, the scheme should be completely comprehensive in all details.

Each of the other 190 projects submitted by the Maritime provinces is also of real significance. It is not possible at this time to describe them all in detail. This we can say, however—taking them as a whole, they indicate the development of a pattern which, as it unfolds, should provide in this oldest area of Canada a health service of which the whole Dominion can be justly proud.

Continued Expansion

The national health program is continuing to expand in the new fiscal year which we have entered. Already we are substantially ahead of last year's rate of progress. As at June 8, more than $12,000,000 of the $31,272,000 available this year had been allocated under projects continuing from last year.

Lack of sufficient staff is still the bottle-neck in all the provinces although some personnel are being made available as a result of the training program commenced last year. As more and more people are trained, more and more projects will be put into operation. We can soon expect to see definite results in better health for all our people.

With respect to the hospital construction grant alone, during little more than the first two months of the present fiscal year projects totalling over $6,000,000 have been approved. This is nearly *three times* as much as the *total payments* made last year during the full seven months of operation. Projects approved under the hospital construction grant as at June 10 show federal assistance from the beginning of the program towards the construction of 11,760 new hospital beds.

Hardly a day passes without at least one hospital project being authorized. If the present rate of approval of projects continues, the existing acute shortage of hospital beds should soon be relieved.

The total amount of money approved for hospital construction by both federal and provincial govern-

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Medical Social Service—

A Luxury or a Necessity?

Agnes Tennant Johnston,
Director, Medical Social Service, Montreal General Hospital

MEDICAL social service is not a frill which is added to medical care. It is an integral part of it. It is the practical application of the accepted principle that concern must be for the patient who has the disease as well as for the disease which the patient has. The medical social worker is a member of the team, of which the physician is the leader, which strives to consider the individual and the whole problem of the patient. The following case discussions may serve to illustrate this conception of *total* medical care.

Case No. 1

By November Mrs. Page had been admitted to the hospital for the fourth time during the year. On each occasion her heart was seriously decompensated. Patient efforts had been made to teach her the folly of climbing stairs and undertaking heavy housework, but somehow she persisted. She sometimes neglected to take her digitalis. She was a widow of 47, seemed intelligent, and her concerned adult daughters claimed that there was no real necessity for excessive activity in the home. She was labelled by the hospital as "unco-operative".

The social worker in talking with her discovered that she had seven children, the youngest being twin boys of eight and the eldest a girl of 24. She shared a large rambling house with another family, her bedroom being on the second floor, the kitchen in the basement. Although she herself could neither read nor write, her children were well educated, one having a university degree. Her husband had been killed in a street accident immediately after a quarrel with her. Driven by feelings of inferiority and guilt, she could not give up, as everyone wanted her to, the one activity by which she could serve her children and in which she excelled—her duties as housekeeper and cook.

Although she could not understand her own difficulty completely, her daughters were sympathetic and willing to help. By changing bedrooms, Mrs. Page was able to sleep on the ground floor. The woman with whom she shared the house agreed to give Mrs. Page all the "sitting down" jobs to do, and the children were encouraged to give her praise and gratitude for the many contributions she could make — contributions that had long been taken for granted. Six months later Mrs. Page was attending clinic regularly. There was no indication for re-admission. She often found the restrictions irksome, but encouragement and reassurance combined with a greater sense of well-being and the knowledge that her children appreciated her made the regime worth while.

Case No. 2

Mary, aged 22, came to medical clinic with a history of severe diarrhoea of four weeks duration. Physical examination was essentially negative, but the doctor gained the impression that she was nervous and tense. Mary readily admitted this and said she would be glad to talk to the social worker. She poured out her worry about her boy friend who drank too much, her father's disapproval of him, her reluctance to discuss things with her stepmother, and her lack of opportunity to meet young people. The chance to talk freely about her anxiety seemed to help her to relax immediately. She did not want to displease her father, and she did not really love the only man who paid any attention to her. She was anxious to do something about it. Mary was encouraged to join the Y.M.C.A. co-ed group with two of her friends. She decided to talk to her father about her problem, knowing that he would be sympathetic now that she had decided not to continue to see the man of whom he disapproved so highly. Mary had no more diarrhoea. She was seen by the social worker until she had completed her plans, but it was not necessary for her to see the doctor again.

Case No. 3

Arthur, aged 18, was referred to the hospital by the Boy's Bureau. He had a cleft palate, which the agency felt was interfering with his social adjustment and with his ability to find employment. The social worker learned that the boy was anxious to work on a farm and had agreed to come to the hospital because he believed the operation would immediately enable him to do this. He was actually very fearful of hospitalization and the operation. Arthur's childhood had been a very unhappy one as his mother had left the home when he was a baby and his father had proved very irresponsible and lacking in understanding. The social worker felt that Arthur's wish to go to the farm was prompted by his desire to leave home and to escape the numerous social contacts of city life which his serious speech defect made embarrassing. Although Arthur had a pleasant personality, he was unable to read or write in spite of years of school attendance, could neither tell the time nor count change.

The doctor stated that Arthur's cleft palate could be repaired but

that he would require speech therapy following it. In discussion with the social worker, it was decided that psychometric testing was indicated in order to evaluate Arthur's ability to benefit from speech therapy and further schooling. The operation was deferred in the meantime. Although Arthur's I.Q. was low, it was felt that he could be helped to speak more clearly, and that he could gain practical knowledge from further education. The social worker saw Arthur regularly to help him overcome his fears about surgery, and to help him accept the disappointment of postponing the plan to go to a farm. The Boys' Bureau arranged for him to live for a year at a boys' school where he would get individual attention, an opportunity to learn and to attend speech clinic.

Strengthening Medical Services

Medical skill could overcome on each occasion Mrs. Page's decompensation, it could decide that there was no physical basis for Mary's diarrhoea, and it could repair Arthur's cleft palate. Is this enough? Is the most effective and economical use of medical skill being made if Mrs. Page has to be readmitted again and again until the most scientific treatment can no longer help her, if Mary attends medical clinic indefinitely still complaining of diarrhoea, if Arthur with a good palate goes to a farm still unable to speak and with little hope of using his limited capacities to the best advantage? Doctors are concerned about the total care of patients. The medical social worker, trained to observe and evaluate social data and to relate them to the medical situation, can often strengthen the services of the doctor and make them more meaningful in terms of the individual patient's need.

"Among medical men, there is a growing belief, particularly with the increasing integration of psychiatric concepts with medical theory, that patients can be more satisfactorily restored to health when medical studies and treatment are combined with treatment of unfavourable social and emotional factors.

"The medical social worker's function is to practise case work through the study, evaluation, and treatment of social, economic, and emotional factors related to a patient's illness. Working under the leadership of a physician, her immediate aim is to assist the patient to improve or adjust outer or inner pressures, whether arising from disturbing difficulties in his environment or from personal attitudes and feelings. Although the medical social worker needs to have some understanding of the underlying medical problems, her concern is with what the illness does to the patient, how he feels about it, and his capacity to adjust to it. The implications are that there is something within the patient himself, or within his environment that may be contributing to his illness."*

How does the patient become known to the social worker? Usually he is referred by the physician who in treating him recognizes the existence of a personal or social problem. In many hospitals the physician and social worker have evolved a plan whereby patients with certain diagnoses, such as venereal disease, tuberculosis, epilepsy, carcinoma or peptic ulcer, are all referred to social service. Such a decision is made when the diagnosis is such that there is considerable probability that social and emotional problems are contributing to the disease or are precipitated by it. Referrals to the social worker may also be made by nurses, dietitians, physiotherapists and other hospital personnel as well as by community agencies or by the patient himself. In all cases, the social worker discusses the referral with the doctor and subsequently plans jointly with him on the basis of medical and social data. The worker cannot help the patient to a solution of his problem without an understanding of his diagnosis, treatment and prognosis. The doctor, after consultation with the social worker, may decide to modify his plan in the light of the social and emotional limitations of the patient.

A Specialty Within Social Work

Medical social service is a specialty within the profession of social work. Its basic knowledge and skills are those of the profession. The practice of social work is based on case work. Case work is based on an understanding of human behaviour, on skill in interviewing, and on an ability to help people modify or change their attitudes towards the problems which confront them. The degree of success which is achieved is dependent on many factors including the social worker's own skill, the desire of the patient for help, his ability to use it, and the resources within the community which may be offered to him. Through case work, the social worker helps the patient or client to clarify his own thinking, often by giving free vent to feelings of anxiety, anger or resentment, and thus helps him to formulate his own plan within the limitations of his particular predicament. His problem may be due either to his own personal limitations or to the limitations of his social situation. Contrary to

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**Hale Pragoff: "Areas of Co-operation Between Medical Social Workers and Dietitians." J. Am. Dietet. A., June, 1948.*

Le Service Social Médical

(Un Résumé)

Le service social médical n'est pas un luxe; c'est une partie nécessaire et intégrante des soins médicaux. Bien que ce service entraîne une mise de fonds de la part de l'hôpital, il constitue une économie; économie non seulement pour le patient, le médecin et l'hôpital mais aussi pour la société en général. Il permet au patient de tirer, des soins médicaux, le maximum d'utilité et d'obtenir sa plus parfaite réhabilitation, selon ses limitations. Il aide le médecin à employer ses compétences de la façon la plus constructive possible, pour chaque cas individuel qu'il traite. Il assure à la direction des hôpitaux un usage plus efficace des services qui y sont donnés. Il sert la communauté en indiquant la nécessité de ressources essentielles et en aidant a les développer. Enfin, il réintègre dans la société des citoyens qui, malgré des handicaps physiques, peuvent encore avoir une vie heureuse *et utile.—A.T.J.*

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Administrative Procedures for the SMALL HOSPITAL

M. A. Williams,
Superintendent,
Foam Lake Union Hospital,
Foam Lake, Sask.

THE small rural hospital lends itself readily to business-like organization and management and the administrator is in the fortunate position of being able to follow through all directives. This, of course, is true only of the full-time, on-the-spot administrator. Hospitals which engage part-time secretaries, managers, or supervisors will receive partial benefits only and in most cases are adding duties to an already over-burdened director of nurses.

A main prerequisite of any hospital policy is the understanding and co-operation of the medical staff. This can only be obtained by full and frank discussions with the doctors of all policies that are to be brought into effect. The administrator should remember that each problem must be approached from two levels: the one, the professional view of the doctor who is concerned with the care and treatment of his patients; the other, the business view of the lay administrator. The wise administrator will seek the co-operation of the medical staff. Hard and fast rules are not the answer in the small institution for the administrator must be willing to give and take in order to realize efficiency in the operation of his hospital.

Control of Out-patient Services

A perplexing problem confronting some small hospitals is the control of out-patient services and the revenue realized from that source. This problem was solved at our hospital by the use of a requisition form and the adoption of a policy mutually satisfactory to the medical staff and the hospital. The requisition is provided by the hospital and made available to the doctors at the hospital and at the doctors' offices. The out-patient is then required to present a requisition for the service ordered by the doctor to the appropriate department at the hospital. The heads of the departments are instructed not to perform services to out-patients unless a requisition is received and the work is duly authorized by a hospital official. The adoption of the policy of payment in advance for out-patient services will result in better service at lower cost to the public.

To assist the various departments, x-ray, laboratory, minor surgery room, et cetera, the administrator must prepare a charge sheet outlining the charges for services likely to be rendered. This sheet serves as a ready reference to the individuals who are required to collect charges from out-patients and also eliminates under or over charges. It is preferable for the public to view the charges of the hospital. Our one exception to the above policy is emergency work which is performed at the request of the physician with allowance for completion of the requisition at a more favourable time. A cash box and receipt book should be available at all times to those in charge of out-patient fee collections.

The compilation and tabulation of all out-patient requisitions in the business office ensures the entry of services performed and the recording of out-patient revenue. This is done daily at our hospital, following receipt of the previous day's requisitions from the various departments.

Admission Forms

At our hospital we have found that the use of admission forms will serve many purposes as they convey all information required to admit patients. The classification of the patient (medical, surgical, or obstetrical; and emergency, acute, or elective) greatly assists the director of nurses in choosing a bed for the patient. In the case of admissions, when the account is not guaranteed, an elective case may be deferred until such time as the account may be guaranteed.

At our hospital the accommodation section (public, private, semi-private, or isolation) indicates the direction of the physician and not the wish of the patient. Accommodation ordered by the doctor for medical reasons is not subject to extra charge to the patient. Requests from patients for extra

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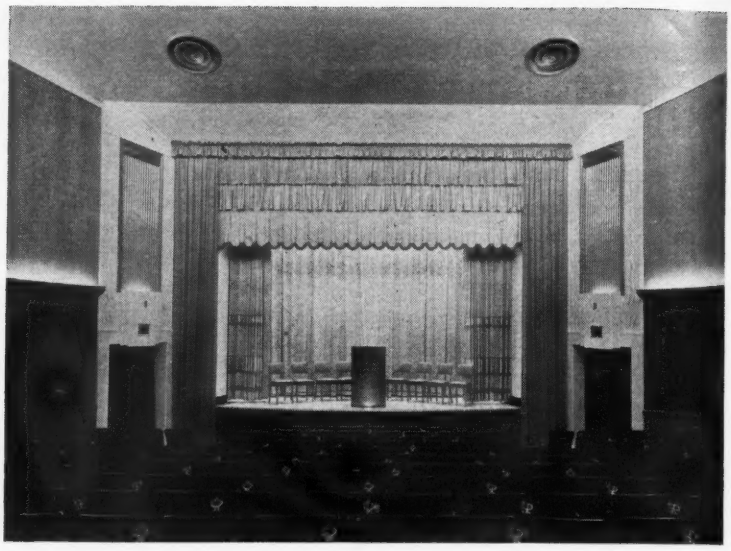
Community Effort Builds Foam Lake Hospital

In operation since February, the 30-bed Foam Lake Union hospital, Foam Lake, Saskatchewan, was officially opened in May. The two-storey building is of frame and stucco construction. The main floor is comprised of general wards, operating wing, laboratory and x-ray departments, nursery, diet kitchen, and nurses' station. The ground floor includes the isolation unit, administration offices, additional public wards, laundry, main kitchen, and dining-rooms. The walls are painted in various pastel shades and the floors are finished in asphalt tile and battleship linoleum. Of the total cost of the project, $155,000, a donation of $27,500 was received from the province and approximately $12,000 will be realized from federal grants.

Increased Space for Technical Facilities at



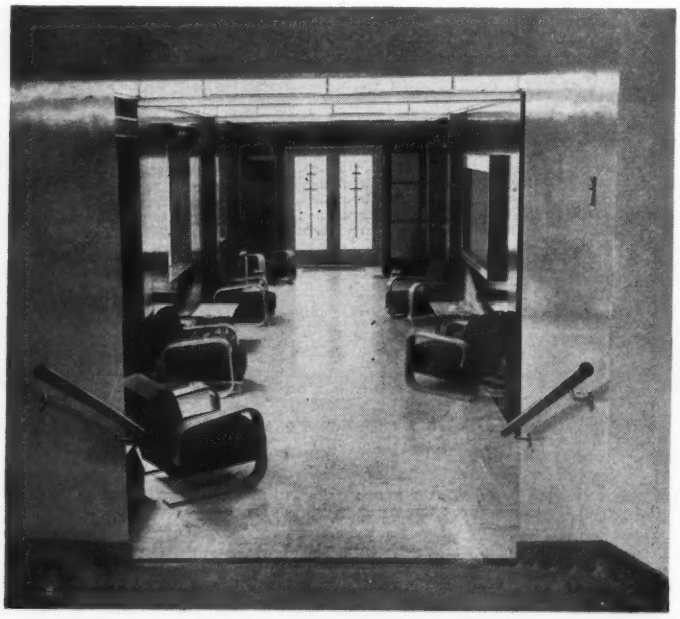
Auditorium

Vancouver Tuberculosis Unit

THE completion of a new addition to the Vancouver Unit of the Division of Tuberculosis Control has created an institute for the diagnosis of pulmonary disease and the treatment of tuberculosis, with complete facilities for handling both in- and out-patients and for undergraduate and postgraduate training.

This new institute has been made possible by the British Columbia Tuberculosis Society whose sole source of revenue is the Christmas Seal Campaign. This Society works as one organization throughout British Columbia, raising its funds through twenty-two local committees whose representatives form a central board.

About two years ago the idea was put forward of adding a wing to the Vancouver Unit of the Division of Tuberculosis Control. Without increasing the bed accommodation, the addition would markedly extend the technical facilities, provinding operating suites, new x-ray equipment, new laboratories, dental surgery, research facilities, up-to-date library, and an auditorium which could be used for patient entertainment, medical and nursing teaching, and lay education. The British Columbia Tuberculosis Society provided over $400,000 for the construction and furnishing of the building. The technical equipment was provided through Dominion health grants.



Foyer

The completely air conditioned concrete and steel building was formally turned over by the British Columbia Tuberculosis Society to the provincial government on May 6, 1949.

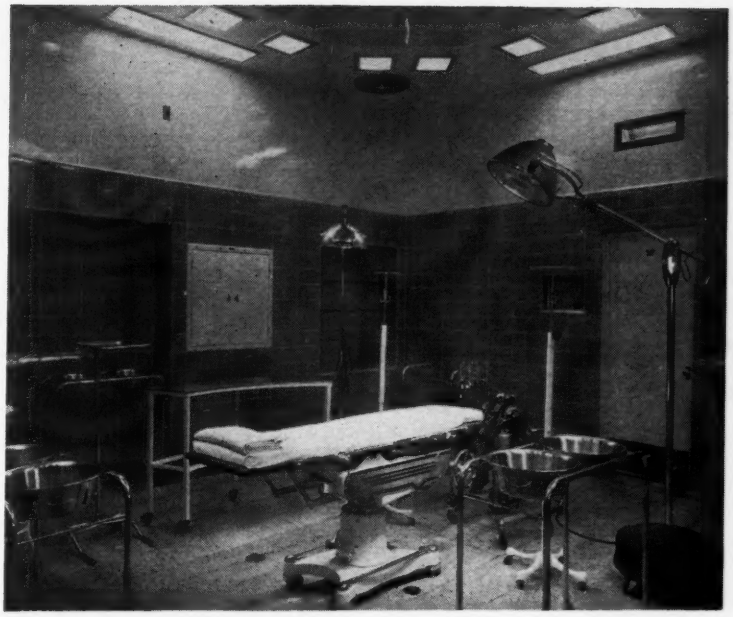
The ground floor is devoted entirely to the auditorium. The foyer, with a pleasing entrance similar to an ordinary theatre, is panelled in mahogany and has an attractive panel lighting system. Off the foyer are washrooms for men and women and a check room. The theatre may be entered from the foyer or down a ramp specially constructed for taking patients

to clinical demonstrations. Two storeys in height and with a seating capacity of three hundred, the theatre has been designed with particular attention to acoustics and indirect lighting. A projection room is housed on the mezzanine floor where there is equipment for the use of 35 or 16 mm. sound films and the projection of lantern slides.

The mezzanine floor also contains the medical library where a qualified medical librarian is in charge. The library includes a large reading room with set-in lighting, mahogany panelled walls, and coloured rubber tile floor, librarian's quarters, and stack rooms.

On the top floor of the building are to be found the laboratories, research and dental surgery departments, and eye, ear, nose, and throat sections. The operating suite includes two recovery rooms, each with two beds, dressing quarters for students, nurses and doctors, and storage space. A waiting room, anaesthetic room, and a large fully equipped bronchoscopic room complete the bronchoscopic section. In addition, an adjacent room houses a biplane fluoroscope and there is to be added a stereoscopic fluoroscope.

Passing through double doors controlled by a central nursing station, one enters the main operating section where are located supply rooms and other work rooms, anaesthetic rooms, and two large operating rooms. The two main operating rooms have a student gallery above with direct vision over the operating table and two-way sound equipment. In addition, this building is wired for television and it is hoped that when this equipment becomes more readily available the operation and operator's description may be transported directly to the auditorum below. Special ceiling lights have been installed to eliminate shadows. There are no windows in the operating suite and each room can be kept, through proper air conditioning, at an even temperature at all times. X-ray equipment is built in the wall of one operating room so that x-ray films may be taken at any time; there is a separate room off the operating room for the x-ray controls and a darkroom for developing.



Operating Room

Thus the addition of this building to an already well equipped out-patient clinic and its correlation with an in-patient service will provide an active centre for the diagnosis and treatment of pulmonary diseases. A rapid turnover of patients will be possible as in the near future there will be a large sanatorium within five miles to which patients may be transferred. This institute will serve as a centre where those cases needing highly developed technical services may be brought from anywhere in British Columbia and will serve as a teaching centre for thoracic diseases.

Canadian Arthritis Society Launches Fellowship Program

An important step taken by the Canadian Arthritis and Rheumatism Society in the concerted attack on arthritis has been the adoption of a program of fellowships for the post-graduate study of rheumatic diseases. The fellowships are designed especially for those desiring further training in internal medicine.

These fellowships are available for study at university centres in Great Britain, the United States, and Canada. They are tenable for a period of twelve months and the amounts will vary from $2,000 to $4,000 per annum in accordance with the candidate's experience and qualifications. The fellowships in the United States will be tenable from October 1, 1949, and those in Great Britain, from January 1, 1950, for a period of twelve months.

Further details can be obtained from the Executive Director, Canadian Arthritis and Rheumatism Society, 74 Sparks Street, Ottawa, or from medical schools.

Dr. T. A. Watson Appointed Director of Sask. Cancer Services

The appointment was recently announced of Dr. Thomas Alastair Watson as Director of Cancer Services for the province of Saskatchewan. Born in New Zealand, Dr. Watson came to Canada in 1946 with a wide practical knowledge of his field obtained from his experiences in New Zealand, China, and England. In addition to the duties of Director of Cancer Services, his appointment includes the actual direction of the Allan Blair Memorial Clinic, Regina, and of the Saskatoon Cancer Clinic.

If Disaster Strikes . . .

How can we ensure continuous hospital service in case of fire, blast, or flood?

Lt.-Col. W. J. McCallum,
Department of National Defence, Ottawa.

THE hospital has become a vitally important institution in the community even when life is what we consider normal but, if disaster strikes, its position assumes, if possible, an even greater importance. In spite of this well known fact, how many hospitals today would find themselves able to function if a disaster struck the community?

No matter what causes the disaster, death and destruction could be brought about by any one of the following: blast effect (the force of an explosion, typhoon, or even an earthquake), fire, flood, high energy radiation, and contamination through chemical and biological means. The first three might immediately render useless the power and water supplies and hence the heating, lighting, sanitation, and general functioning of all equipment in the building—if they do not demolish the building itself. The remaining effects might cause personal danger to the staff and make it difficult for them to function.

In general, we may say that a hospital might be unable to operate because it

(a) is located in the centre of a stricken area,
(b) has no power, water, heat, or sewerage,
(c) has not sufficient staff,
(d) has no equipment or supplies.

Upon examination, the first factor, location, is found to be the greatest obstacle to overcome since many of the best hospitals are in the centre of "target" areas and hence likely to be stricken if an incident occurred. Cost would prohibit the transfer of these buildings but it is possible that additions might be set up as satellites in safer places, reserve buildings could be planned and, if necessary, equipped, and underground chambers could be considered. As research proceeds, it may be that other safeguards will be found.

Location

Since the phrase "location near a target area" is heard very frequently, it might be worthwhile to consider what a target area is. The enemy may attack in a number of ways, the use of atom bombs being only one. H.E. and fire, from aerial attack or sabotage, are the more probable.

Aerial attack, at least at first, is strategically economical only on what the enemy considers very vital targets; these would usually be located in areas of high population density, such as industrial and communication centres. What are considered definite target areas today may not be so considered in a few years. The enemy must weigh his possible gains against the cost and effort involved. Strategic gain must be weighed against the practical difficulties of application.

Sabotage, however, is a different matter; it would be carried out by those of us who had fallen for enemy propaganda. When one considers the distasteful but nevertheless true idea—that Canadians may be the saboteurs—it can readily be seen that no place is secure and the old enemy weapons can be loosed anywhere at little cost. However, the greatest danger will still be in congested areas, industrial localities, and centres of communication.

If it is located outside a city or in a residential area well removed from densely populated areas, factories, railways, airports, et cetera, the hospital then has every right to expect to escape damage. Distance, as well as the contour of the land, will cause great variations. An expert should be consulted in each individual case.

Although city hospitals receive patients from nearby smaller towns, possibly at the expense of the growth of the small hospitals, the latter will play a very important part if city institutions are incapacitated. Some thought might be given to this when planning medical care in a metropolitan area in an emergency. Could they be used as satellites of the larger ones in the danger area? Could they be considered the reserves of the metropolitan area?

In England tented hospitals are under consideration; school buildings are regarded as unsuitable. During a great part of the year in Canada, tents are not feasible and research must be carried out on light, mobile, easily stored and erected shelters, capable of expansion into various sizes. Underground chambers could be established under the present hospitals but egress and access must be considered in the event that the surrounding area may be demolished or burning. Again, it is a problem for the engineer to decide.

Electricity, Water, Light

In considering the danger consequent upon the interruption of power, water supply, heat, and sewerage, it can readily be seen that the hospitals must find some means of being independent in these services. It would involve the installation of an independent power source and water supply integrated with the hospital and a separate sewerage system to be used only in an emergency. These are expensive although many hospitals may have them in part even now. These problems may not be as difficult as they appear at first.

Staff

The problem of staff is one which must be considered in relation to the total needs of the

From an address presented at the Biennial Meeting of the Canadian Hospital Council, May, 1949.

country and, therefore, it will be receiving careful study at the highest levels. As previously, medical officers will be required in the Armed Services and the supply will probably not meet the total demand. This will also apply to nurses. In addition, in the event of another war, with hospitals located in probable target areas and many nurses and doctors living close to them, a large part of this skilled staff may be killed or incapacitated if the hospital or neighbourhood is hit. It must be remembered that, if highly trained medical personnel are lost through poor location of hospitals and residences, the loss will be much more serious than that of buildings or equipment.

The manpower problem, almost certain to arise in the event of war, may be helped considerably through a study of shorter courses for nurses, a task analysis to determine where highly trained personnel may be used economically and where less education will suffice for certain types of work.

Equipment and Supplies

Very little medical equipment and supplies are manufactured in Canada; a large percentage of our drugs come from the United States. During the last war supplies were scarce not because factories were damaged but because the material had to go to the American forces. In another war, we must consider the possibility of having the source of supply cut off for an additional reason, that is, damage to factories by enemy action. Due regard must be given, therefore, to preparing a list of requirements and to stockpiling equipment and drugs wherever possible. Stockpiles must be well dispersed to avoid over-concentration in one location.

Civil Defence

Although I have touched broadly on what might happen to a hospital, its staff, and supplies, I have omitted to refer to civil defence. In Canada, civil defence is still in the research stage and hence we are unable to do more than indicate some of the problems. One of the principles we are following is that the autonomy of the province or municipality will be respected and the same must apply to any organization which may assist. While this may make the planning more difficult, the eventual organization will be more acceptable to our way of living.

Much is top secret, known only to those dealing directly with it, but all information possible will be passed on to the hospitals to assist them in their planning.

* * * *

Western Institute for Administrators to be Held in Regina

From October 3 to 8 the Western Canada Institute for Hospital Administrators and Trustees will be held at the Saskatchewan Hotel in Regina under the joint sponsorship of the Hospital Services Planning Commission of Saskatchewan and the Saskatchewan Hospital Association, with the assistance of the three other Western associations. The Institute will favour short addresses and informal discussion periods of value to hospitals large and small. A preliminary program has been drawn up by the Program Committee, under the chairmanship of Dr. H. E. Baird, and features such topics as hospital decorating, medical procedure, problems of the small hospital, and point system of hospital rating.

Those who plan to attend the Institute are urged to send in their applications early. These, together with the registration fee of $15, should be forwarded to Mr. John Smith, General Secretary, Western Canada Institute, Yorkton Hospital, Yorkton, Sask.

Si le Désastre Frappes . .

Un Résumé

L'hôpital est devenu une institution vitale dans la communauté même dans les jours normaux. Sa position devient encore plus importante en temps de désastre. Quoi que soit la cause du désastre, la maladie et la mort suivent toujours, et alors il faut que les hôpitaux fonctionnent.

En général, nous pouvons dire qu'un hôpital ne peut pas fonctionner si :

(a) il est au centre d'une section frappée,

(b) il n'a pas d'électricité, d'eau, de feu, ni de drainage,

(c) il n'a pas un personnel suffisant,

(d) il n'a ni instruments ni provisions.

Le premier facteur est le plus difficile à surmonter parce que beaucoup des meilleurs hôpitaux sont dans les "target areas", c'est-à-dire, des sections bien peuplées, des centres d'industrie ou de commerce, qui seraient les premiers à être attaqués. Ces hôpitaux ne peuvent pas être transportés à d'autres endroits mais des extensions et des abris devraient être construits dans des sections moins peuplées, et on devrait faire une recherche au sujet de la construction d'édifices légers, faciles à transporter et à ériger.

Quand on considère le danger que causerait une interromption d'électricité, d'eau, de feu, ou de drainage, on voit clairement que les hôpitaux devraient avoir un système pour les rendre indépendents de ces services publiques.

La question de personnel doit être examinée du point de vue des besoins du pays entier. En cas de guerre, beaucoup de docteurs et d'hospitalières seraient dans l'armée. Ceux qui travailleraient aux hôpitaux dans les "target areas" pourraient bien être tués ou blessés si l'hôpital ou les environs étaient frappés. La perte de ce personnel serait beaucoup plus sérieuse qu'aucune perte d'équipement. Le manque de garde-malades pourrait être amelioré si le cours était raccourçi et si on se servait d'employées moins instruites pour les travaux routiniers.

Les provisions médicaux du Canada viennent principalement des Etats-Unis. En temps de guerre, les Etats-Unis ont besoin eux-mêmes de la grande partie de leurs provisions, alors le Canada devrait commencer à accumuler des réserves de ces produits dans des endroits isolés de la campagne.

On fait encore de la recherche au sujet de la défense civile et tout est un secret. Quand nous obtenons de l'information, nous le donnerons aux hôpitaux pour leur aider dans leurs plans.

Physicians' Art Salon

Reveals Much Talent

"The New Scarf"

THE Physicians' Art Salon held in connection with the Saskatoon meeting of the Canadian Medical Association drew the largest number of entries ever received and was in many respects the best yet in the quality of the exhibits.

Sponsored by Frank W. Horner Ltd. and under the direct supervision of Mr. D. B. Mahoney of Montreal, this art exhibit of paintings, photographs, and etchings by physicians has become a popular feature of the medical convention.

First award in the Fine Art Section went to Dr. Anna Gelber of Toronto, a fairly recent recruit to the fascinating art of painting, who has consistently gained higher awards each year (see *The Canadian Hospital,* Nov. 1948, page 39). "The New Scarf", in vivid hues, needs colour reproduction to do it justice.

Lt.-Col. C. G. Wood of Ottawa took first award for Monochrome Photography with his "Lachesis". In Colour Photography, first prize went to Dr. Griffith Binning of Saskatoon with "Three Children".

The undergraduates also had a panel which revealed much budding talent and speaks well for competition in the senior groups later on. Here first award in the Fine Art Section went to John S. Henry of Montreal with "Old Barn—Bonaventure Island". In Monochrome Photography, Morris Resnick of Toronto was first with "ooOOH!". The Colour Photography award went to Claude Jutras of Montreal with "Fishes in the Sun".

"Lachesis"

Award Winners

The complete list of awards given by the judges, Reta S. Cowley, G. W. Snelgrove, Ph.D., and L. G. Saunders, Ph.D., A.R.P.S., is as follows:

SENIOR

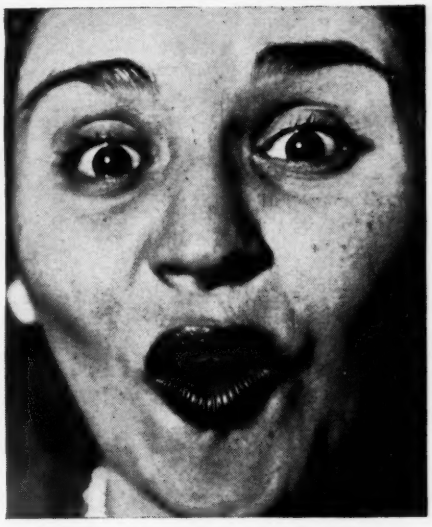
Fine Art

First Prize
Dr. Anna D. Gelber, Toronto
"The New Scarf"

Second Prize
Dr. John H. Toogood, Montreal
"Heart of Darkness"

Third Prize
Dr. H. J. Laudan, Saskatoon
"The Green Vase"

Awards of Merit
Dr. G. E. Tremble, Montreal
"Late Afternoon Near Ste. Agathe"
Dr. Robert C. Riley, Calgary
"The Three Sisters"



Top left: "Old Barn—Bonaventure Island"

Top Right: "ooOOH!"

Left: "Portrait"

Dr. Anna Wilson, Winnipeg
"Social Security"
Dr. Harvey Agnew, Toronto
"Market—St. Vincent"
Dr. A. E. Robertson, Essondale, [B.C.
"Portrait"

Monochrome Photography

First Prize
Lt.-Col. C. G. Wood, Ottawa
"Lachesis"

Second Prize
Dr. Stuart M. Rose, Lethbridge
"Peaceful Valley"

Third Prize
Dr. L. J. Notkin, Montreal
"Fragile Icing"

Awards of Merit
Dr. G. B. White, Port Colborne, [Ont.
"Song at Twilight"
Dr. Stanley Greenhill, Edmonton
"Between Catches"
Dr. D. C. Eaglesham, Guelph
"Porthole View of New York"
Dr. W. P. Goldman, Vancouver
"Enchanted Forest"

Colour Photography

First Prize
Dr. Griffith Binning, Saskatoon
"Three Children"

Second Prize
Dr. T. M. Jones, Victoria
"Autumn in B.C."

Third Prize
Dr. J. F. Burgess, Montreal
"Coprinus"

Awards of Merit
Dr. L. M. Edmunds, Smoky [Lake, Alta.
"Susan's Bath"
Dr. F. E. Wait, Saskatoon
"Thunderhead"
Dr. D. C. MacDonald, N. Battle- [ford, Sask.
"Oxteam"
Dr. J. T. MacKay, Saskatoon
"Water-lilies"

UNDERGRADUATE

Fine Art

First Prize
John S. Henry, Montreal
"Old Barn—Bonaventure Island"

Second Prize
D. G. Watson, Port Credit, Ont.
"June—Stoney Lake"

Third Prize
Robert A. Love, Quebec
"Old Friends"

Awards of Merit
Claude Jutras, Montreal
"Cabane"
J. Allister Weir, Toronto
"Black Explosive"

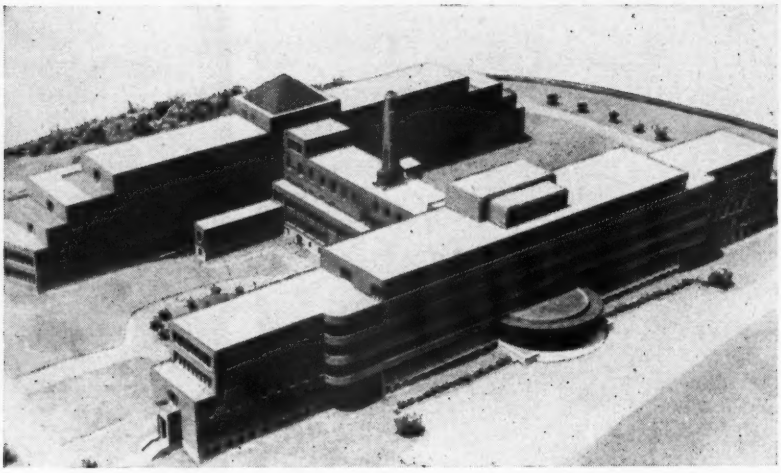
Monochrome Photography

First Prize
Morris Resnick, Toronto
"ooOOH!"

Second Prize
Claude Jutras, Montreal
"Motif"

Colour Photography

First Prize
Claude Jutras, Montreal
"Fishes in the Sun"



Sanatorium St. Georges de Mont-Joli Dedicates Wing on Tenth Anniversary

THE tenth anniversary of the founding of the Sanatorium St. Georges at Mont-Joli, Quebec, was marked in July with the dedication of a large new wing. This modern addition to the institution, which is a well-known centre for pulmonary tuberculosis cases, almost doubles the former bed capacity. It now provides 620 beds, including accommodation for 25 children.

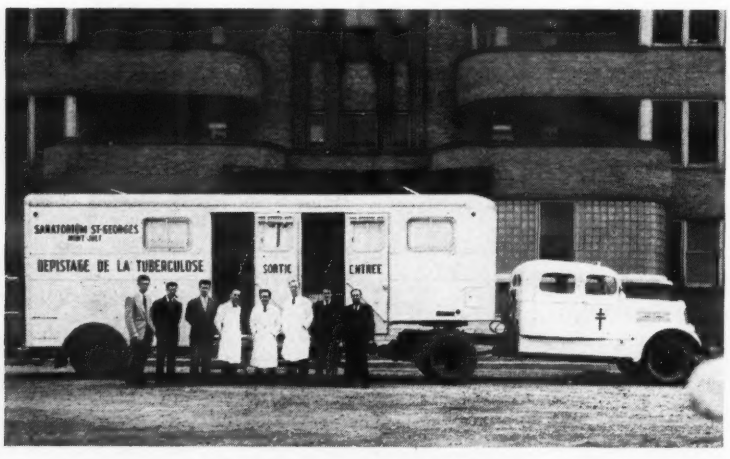
Constructed of reinforced concrete, with exterior walls of brick, the wing contains five floors and two basements. In the surgical department, operating rooms are equipped both for minor and major operations.

Patients may take advantage of the educational facilities offered by the Sanatorium. Three times a week the director of the Rheault Institute of Mont-Joli comes to give instruction to the patients and the Quebec government provides all necessary equipment.

Instrumental in no small way in the growth and influence of the institution has been its tuberculosis prevention and detection program, which includes the wide use of a large trailer-truck mobile x-ray unit. Operating costs are defrayed by the proceeds from the Christmas Seal Campaign conducted throughout the lower St. Lawrence area.

With the recent extension, the Sanatorium St. Georges is now the largest in Quebec for the treatment of pulmonary tuberculosis and it extends its area of operation to two-thirds of the Gaspesia Peninsula. Chest clinics of the Sanatorium cover a territory of about 250 square miles, including the counties of Matapedia, Rimouski, Rivière du Loup, Kamouraska, and Temiscouata, and the north shore of the St. Lawrence from La Malbaie to Seven Islands.

The Reverend Filles de la Sagesse are responsible for the direction of the Sanatorium and the administration staff includes Dr. J. A. Couillard, medical director, Dr. Herman Gauthier, chief doctor, and Georges-Henri de Champlain, treasurer.



Sanatorium St. Georges Mobile X-ray Unit

Pharmacy Problems of the Smaller Hospital

Dorothy Bowden, Reg.N.,
Superintendent,
Norfolk General Hospital,
Simcoe, Ontario.

IN contemplating the means of assisting small hospitals when neither a full-time pharmacist nor manufacturing is available, two points must be taken into consideration, (a) controls and (b) hospital formulary.

Lack of control is one of the great weaknesses of a hospital which has no organized pharmacy. Two main sources of this lack of control, from which many difficulties spring, are the variety of drugs and the accounting methods.

Variety of Drugs

Most of us are striving to limit drugs having similar therapeutic action. The minimum standard for pharmacies, published by the American College of Surgeons, states that the duties of a pharmacy committee are:

1. to add to and delete from drugs used;

2. to supervise the purchase and issuance of drugs, chemicals, pharmaceutical preparations, biologicals, and professional supplies within the hospital.

In the small hospital this committee may comprise one physician, the dispenser, and the superintendent. They form the nucleus from which contacts are made with all other departments. The physician pharmacist may give guidance to the purchasing agent and act as a liaison officer between administration, nursing, and medical staffs. Is it not plausible that routines would more likely be adhered to if changes were presented by the physician pharmacist, discussed by the medical staff, and approved by the joint medical advisory committee? Employing less costly drugs and simplifying and reducing purchases could well constitute a major saving.

For years complaints have been made about identical drugs and the variety of drugs sold under various trade names. To assist the superintendent of the small hospital when a new drug or new trade name is proffered, it may be helpful to inquire which drug store is stocking the product. This will assist the medical staff by making the product available. It will, also, probably reduce the inventory, save time and money, and eliminate the use of some new drugs which may not be valuable to a hospital pharmacy. If the drug is of value it would, in any case, be recommended at the next meeting of the pharmacy committee.

Ward Stock

Control of ward stock is best maintained by keeping at a minimum the amounts issued. If a 16-ounce bottle is more than sufficient for daily requirements use a 10-ounce. This is particularly essential for the control of narcotics because of addiction dangers. There are usually twelve daily requisitions but a 60-bed ward would probably need 24. Forms should be provided for checking and they should be signed by the nurse at every change of shift. Stock supply should be stored preferably in a safe, the combination of which is known only by a limited number of the staff.

Perpetual Inventory

The primary requisite for efficient control is the establishment of a perpetual inventory. Each card should show at a glance the amounts issued and received, a comparison of prices, order numbers, and other pertinent data. A competent bookkeeper can readily be trained to post the inventory cards, to stamp and check invoices, and to write the orders for routine purchases. The superintendent would have only to sign the prepared orders and approve the invoices.

Many hospitals include "routine drugs" as part of the service given in standard care, no charge being made except that of room rate. We found that there was no criterion for a "routine drug", a fact which caused considerable confusion. To eliminate this we established a charge for every drug used. If a patient's drug charges are less than 15 cents per day, no charge is made; otherwise he is charged for all drugs used. As we have no pharmacist, we co-ordinated nursing supervision with drug charges. This was done by having a summary (or total voucher sheet) completed daily by the relief supervisor who is also the dispenser. In a large hospital this would be impracticable but in the smaller hospital it seems the least costly method. It was fundamentally necessary to re-organize work schedules and arrange time so that there was no conflict with other departmental duties. This arrangement has facilitated two noticeable improvements:

(a) accurate daily drug charges;

(b) closer nursing supervision.

The voucher lists the name of and the products used by each patient. Three columns are completed by the business office and these show both the charge for the drug and the administration, the total being the charge for accounting purposes. As these voucher summaries show the total administration charge for injectibles, we shall be using them as reports to the Federal Department

From an address presented at the annual conference of the Regional Hospital Council of Districts No. 1 and No. 2, St. Thomas, Ont., May, 1949.

of Excise. Last March hospitals received notice of this exemption from the Deputy Minister of National Revenue to the effect that: "In the case of any drugs, medicines or other therapeutic or pharmaceutical products which require administration, if a separate charge is made to the patient for administration, such charge would not be taxable, otherwise the tax applies on the entire charge made if this exceeds the purchase price of the item by the hospital, plus 10 per cent, even though the charge includes the cost of administration." We understand this to mean that, if a charge is made for the nursing service—administration of, for example, procaine penicillin — and that charge is made separately from the cost of the drug, then the administration charge is exempt from sales tax. We hope to have, not a large, but a worthwhile annual saving.

Is your financial statement satisfactory? Does it show departmental comparisons of the cost of drugs used with revenue from the sale of drugs? It is necessary for the administrator to know whether the pharmacy is a liability or an asset. In the system of voucher charging which has just been outlined we make no exception for the indigent patient. True, there are no receipts for those extra charges, but we are able to ascertain the actual cost of gratuitous services being rendered. Perhaps this would be of value to you in making application for municipal grants.

Standard Formulary

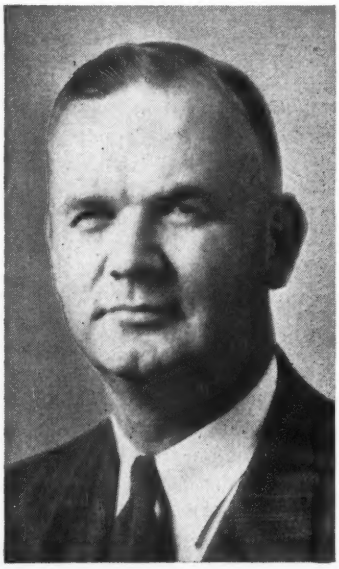
Most small hospitals have either no formulary or an obsolete one. Some years ago the Canadian Hospital Council published a brief formulary for use in hospitals. (Bulletin No. 20.) Probably this bulletin could be used more extensively.* A very detailed piece of work would be necessary to ensure the success of a standard formulary. If it is to be of practical use to the small hospital, it must include every drug used or advised for use. As these drugs change frequently, such a formulary should be of loose leaf style similar to the price catalogues of the drug manufacturers. Surely where there is a full-time pharmacist employed he should aim to have a perpetual formulary to assist him in his work. I am particularly interested in those hospitals which have no pharmacists or, at best, one acting part-time or in an advisory capacity only. They require a perpetual list of the materials to be kept in stock and the form (ampoules, hypo tablets, et cetera). This formulary should also include prescriptions which may be procured from the local druggist and kept stocked in the hospital pharmacy. A more comprehensive formulary, therefore, would improve the efficiency and economical operation of our hospitals as well as provide easy reference for both medical and nursing staffs.

*"*The Physicians' Formulary", issued by the Canadian Medical Association in 1946, is now used by many hospitals.*

Dr. Crozier Accepts Fine Post in Texas

Dr. Leigh J. Crozier, who resigned his position as administrator of the Victoria Hospital in London some months ago, has accepted the post of administrator at Hermann Hospital in Houston, Texas. Dr. Crozier assumes his new duties about the middle of August.

Hermann Hospital is made up of two units, comprising some 750 beds for active treatment. Unit No. 1 of some 300 beds was erected in 1925 and the new and larger unit No. 2, air-conditioned throughout, has just been completed. Hermann Hospital is an integral part of the huge $100,000,000 Medical Centre now being developed in Houston. (See *Hospital Management*, July, 1946.) This great centre, being developed in a 161-acre parkland, will bring together in its medical work four universities — Baylor University, the University of Texas, the University of Houston, and the Rice Institute—and twelve or more hospitals.



Leigh J. Crozier, M.D.

Among the other hospitals which have been, or will be, constructed in the Centre are the M. D. Anderson Hospital for Cancer Research, the Methodist Hospital, St. Luke's Episcopal Hospital, the Tuberculosis Hospital, the Children's Hospital, the Urological Hospital, a Psychosomatic Pavilion, and a Maternity Pavilion. A Convalescent Hospital and a Hospital for Chronic Diseases and the Aged are planned. A $12,000,000 Naval Hospital two blocks away will co-operate in the program, an $8,000,000 Veterans' Hospital is close by, and a Marine Hospital is being erected in the Centre. There will be a medical school, a post-graduate medical school, a school of public health, an institute of geographic medicine, a medical library, a dental school, and a Hermann Professional Building.

Dr. Crozier was born in Prince Edward Island and was graduated from McGill University in 1935, following which he did three years of postgraduate work in Montreal and Boston. He practised in Chapleau from 1938 to 1943, then assumed the position of superintendent of Victoria Hospital in London until his resignation in 1948. During the past year he has been associated with Dr. M. T. MacEachern in the School of Hospital Administration at Northwestern University in Chicago.

All good wishes, Leigh!

DES VISITES A L'HOPITAL

Part IV

ACCUEIL DU VISITEUR

*"Aimer, c'est servir par excellence, donner lorsqu'on ne possède plus rien qu'un sourire et rester envers et contre tout une étincelle de bonté et de lumière."**

S. S.-Adolphe, O.S.A.,
R.N., C.Sc.H.
Surintendante, Hôtel-Dieu de Québec, Québec.

DANS les hôpitaux de petites villes qui dépendent jusqu'à un certain point de la charité privée, il est bien difficile de refuser la faveur occasionnelle d'une visite en dehors des heures fixées. Les heures de visite sont un problème difficile pour tous les hôpitaux. Il n'y a probablement pas de solution parfaite.

On ne peut mettre sans distinction, sur le même pied, des gens de milieux intellectuels et sociaux différents. Il sera, par example, beaucoup plus facile de limiter le nombre de visiteurs que recevra un hospitalisé dans une salle qu'il le sera de faire la même chose dans le cas d'un professionnel admis simplement pour se reposer. On ne saurait croire à l'inconséquence qu'affichent sur ce point des gens pourtant intelligents.

Personne n'a besoin de se faire dire que le programme des relations publiques commence à la porte d'entrée. Avec une bonne administration, les visiteurs peuvent présenter une occasion précieuse pour de bonnes relations sociales. Pour atteindre ce but, un hôpital doit faire montre de nombreuses qualités: la compétence, la charité, l'esprit scientifique et la passion du progrès médical. Mais il n'est pas une seule de ces qualités qui suffise à assurer à l'institution cette entière confiance du public, sans laquelle l'hôpital ne saurait répondre aux besoins médicaux de la société. L'hôpital doit posséder une personnalité bien à lui, inspirer la confiance, s'attirer des amis et les conserver. La personnalité est quelque chose de complexe, mais lorsqu'il s'agit d'un établissement elle défie l'analyse. Nous savons cependant qu'il faut des années pour la former et qu'un geste irréfléchi ou mal avisé d'un membre du personnel peut détruire, et pour longtemps, ce qu'avaient édifié les autres membres au prix de patients efforts.

C'est l'infirmière surtout qui peut créer une impression favorable, en donnant avec soin et patience, lorsqu'il y a lieu, toutes les explications requises pour guider le visiteur. Les préposées aux renseignements et au téléphone peuvent faire beaucoup. C'est pourquoi il faut choisir ces responsables avec grand discernement.

Il y a quelques années un administrateur d'expérience choisit tel hôpital pour se faire traiter, simplement parce qu'il avait été bien impressionné de la manière courtoise de la téléphoniste. C'est la forme que celle-ci doit soigner. Le "Que voulez-vous?" n'aura jamais l'effet du "Puis-je vous être utile?"

Les relations de l'hôpital avec le public doivent donc être cordiales et loyales pour gagner la confiance. Les parents sont ordinairement inquiets de leurs chers hospitalisés et ils sont, par le fait même, exigeants et difficiles à satisfaire. Les relations, avec la famille du malade, demandent beaucoup de tact, de la courtoisie, de la considération, de la patience, à cause des plaintes plus ou moins fondées dont elle peut se prévaloir. On le sait, tous les visiteurs qui viennent en contact avec l'hôpital font sa bonne ou sa mauvaise renommée en parlant de ce qu'ils y ont vu et entendu. On y rencontre des gens de toute espèce qu'il faut traiter avec circonspection.

A l'infirmière qui serait tentée de considérer le visiteur comme un *embarras*, suggérons une scène de l'Evangile, celle de la Chananéenne. La Chananéenne en effet incarne la mentalité de certains parents qui entourent nos malades et dont l'affection inquiète, impatiente, égoiste, pensons-nous, nous harcèle de recommandations, de questions, mettant à mal notre patience. Souvenons-nous alors, de l'exemple d'indulgence, de douceur, d'émotion profonde donné par Jésus à ceux qui ont mission d'adoucir l'angoisse des mères: loin de blâmer les exigences de leur amour, il loue leur foi et souligne que c'est à cette persévérance dans la confiance qu'elles obtiennent ce qu'elles veulent. Et pour être capables d'élargir ainsi notre coeur afin qu'il devienne ce qu'on nomme *un grand coeur*, prions le Christ, maître de l'amour, d'intensifier toujours davantage, en chacune de nos âmes, la surnaturelle puissance d'une tendre et forte compassion.

SUGGESTIONS

Nous l'avons vu, si un administrateur d'hôpital peut oublier tous ses autres problèmes, il lui reste un *cauchemar:* celui des visiteurs. Et pourtant le lien d'intérêt mutuel qui doit exister entre l'institution et les visiteurs doit l'inciter sans cesse à une meilleure collaboration.

Pour réaliser ce but, voici quelques suggestions.

1. Former un comité composé de représentants de tous les hôpitaux de la région. Ce comité étudierait les moyens d'établir un règlement adéquat que le personnel de chaque hôpital du district devrait ensuite tenter d'appliquer de son mieux, sans ignorer cependant le côté "humain" du problème.

2. Essayer d'obtenir la coopération du corps médical qui devrait déconseiller les visites à l'hôpital en temps importun, et seconder les

**R. L. dans "Notre Voix" 5-11-47.*

directions de l'administration en la matière.

3. Un feuillet, papillon ou tract, ou "guide des clients", donnera peut-être des résultats si l'on y décrit en termes bien choisis les avantages et les désavantages qu'offrent les visites à l'hôpital.

En voici quelques items: notre longue expérience nous suggère ces quelques conseils, sachant votre désir de coopérer avec nous pour le prompt rétablissement de nos malades.

Que vos visites ne soient pas trop fréquentes. Une note ou des fleurs témoigneront aussi bien de votre sympathie.
Le tact est plus précieux que l'or dans une chambre de malade.
Etre joyeux, naturel, parler à voix basse.
Converser sur ce qui intéresse le malade; éviter les nouvelles tristes et ennuyeuses.
Montrer de la sympathie.
Cacher votre inquiétude ou votre anxiété.
Rassurer le malade.
Cultiver l'espoir en la guérison.
Parler peu de sa maladie, vu qu'il lui faut l'oublier.
Fournir une lecture choisie selon l'état d'esprit du malade.
Ne pas fumer même si l'on vous l'offre.
Quitter la chambre si le malade doit recevoir un traitement.
Ne pas visiter un malade si vous avez le rhume.

Il est reconnu que les hôpitaux qui distribuent un feuillet expliquant les raisons des restrictions ont moins de difficultés avec leurs visiteurs.

Ceci n'empêche pas la bonté et la courtoisie à l'égard de ceux qui ne sont pas familiers avec l'hôpital. De ceux-ci, il faut se faire des amis.

4. L'hôpital devrait aussi se créer une "personnalité". On n'y arrivera qu'en faisant équipe. Chaque employé de l'hôpital doit se rendre compte qu'il lui incombe de faire grandir la confiance, tant des malades que du public, en l'institution. Des réunions des employés ou des assemblées du personnel stimuleront le sens de la responsabilité que tous doivent posséder si l'on désire atteindre ce but.

5. L'aide du conseil des hôpitaux: la plus grande difficulté dans le contrôle des visites, c'est le manque d'uniformité dans les divers hôpitaux. Dans une ville où il y a deux hôpitaux et plus, l'institution qui impose des restrictions se place dans un état d'infériorité auprès des autres. Certains hôpitaux de grandes villes ont cependant résolu ce problème. Le conseil des hôpitaux a formulé des règlements uniformes qu'ont adoptés tous les hôpitaux de la localité.

Afin d'aider les hôpitaux qui trouvent difficile de faire montre de sévérité à propos des visites, des envois de fleurs ou des appels téléphoniques, le conseil des directeurs de l'"Ontario Hospital Association" a adopté une motion par laquelle il demande aux hôpitaux de faire pression auprès des habitants des environs (vue la rareté de la main d'oeuvre) afin qu'ils réduisent autant que possible le nombre de leurs visites, de leurs envois de fleurs et de leurs appels téléphoniques à l'hôpital. Ce geste est ensuite soutenu par une campagne de publicité.

6. Campagne de publicité adopter une motion, c'est bien, mais encore faut-il la faire connaître au public. Une campagne de publicité bien dirigée complète le projet. La voix des journaux, de la radio, ainsi que l'usage du haut-parleur dans les différentes sections de l'hôpital, annoncera et expliquera un programme bien défini et une réglementation précise.

A la suite d'une hausse de mortalité infantile qui se produisait récemment dans un hôpital de Chicago, le président du bureau de santé municipale a simplifié le problème des visites en adressant à tous les hôpitaux de sa juridiction le télégramme suivant: "S.V.P. faire observer immédiatement le règlement qui défend aux visiteurs d'avoir accès auprès des enfants . . . . prière de bien afficher ce télégramme à la vue de tous les visiteurs."

Le Conseil des Hôpitaux de Chicago suggère une liste d'heures de visite pour les malades des hôpitaux en divisant les services en trois groupes: chez les adultes, en obstétrique, en pédiatrie. Si les exceptions sont étroitement contrôlées, le public aura plus de respect pour les règlements. Ces divisions sont tout à fait logiques dans les grands hôpitaux.

Voici ce que viennent de conclure les hôpitaux de Québec et de Lévis, sous le patronage de l'Association des Hôpitaux Catholiques, Conférence de Québec.

(concluê en page 74)

Newly Elected Officers of the Catholic Hospital Association

The Rev. John W. Barrett (centre), Archdiocesan Director of Hospitals, Chicago, Ill., was elected President of the Catholic Hospital Association on June 15th at the organization's Thirty-Fourth Annual Convention. Father Barrett has been active in the Catholic Hospital Association for the past 19 years. In addition to his new position, he is trustee of the American Hospital Association, President of the Chicago Hospital Council, and a member of the Executive Committee of the National Health Association. Others elected to important posts were the Right Rev. Msgr. John R. Mulroy of Denver, Colo. (left), former Vice-president of the American Hospital Association, who was chosen President Elect, and the Right Rev. Msgr. H. Joseph Jacobi of New Orleans, La. (right), who now has the post of First Vice-President. The Right Rev. Maurice F. Griffin, Cleveland, O., past president of the organization, is the new Second Vice-President.

The Dietetic Internship

Elizabeth M. Lawson,
Director of Dietetics,
Royal Jubilee Hospital, Victoria, B.C.

"WHAT is a qualified dietitian?" and "What must I do to become a dietitian?" are two familiar questions asked the high school teacher and professor of home economics today.

A dietitian has been defined as "one who has had college training in the science of nutrition and management and is proficient in the art of feeding individuals and groups". A bachelor's degree from a fully accredited university, with foods and nutrition as a major study, is required. In order to acquire proficiency and to be adequately prepared professionally, the Canadian Dietetic Association recommends a year of approved internship. The position of the dietetic intern is analogous to that of a medical or hospital administration intern in obtaining directed experience. The purpose of an internship is the expansion and integration of academic preparation with the comprehensive responsibilities and duties of the profession. Assignments are scheduled so that dietetic interns have supervised practice and responsibility in the many phases of dietetic work which may be required of them in future positions. Besides practical assignments they receive class instruction in the form of seminars, conferences, demonstrations, ward rounds, and lectures by specialists from representative fields.

Approved Internships

The Canadian Dietetic Association has approved three internships in the administrative field, ten in the hospital field and one in the nutritional field. Since hospitals employ the greatest number of dietitians, this article will be confined to hospital internship.

Hospitals offering this fifth year of work to graduate dietitians must be approved by the American College of Surgeons, have a training school for nurses accredited by the Canadian Nurses' Association, and have at least 125 beds. The dietetic staff must consist of at least two graduate dietitians who are active members of the Canadian Dietetic Association (minimum only for the above number of beds). The proportion of interns to graduate staff must never exceed three interns to one graduate. The intern is received in the hospital on a post-graduate basis and receives a certificate upon successful completion of her course. She is entitled to membership in the official organization of the profession, The Canadian Dietetic Association.

The Program

The general organization of the training course for dietitians includes provision for:

1. The constant enrolment of at least two dietetic interns.

2. A program covering one year to be divided approximately as follows:

   (a) One third in general problems of food administration;

   (b) One third in diet therapy, including experience in diets of in-patients and out-patients and, if possible, in the nutrition services of a public health agency;

   (c) One third in infant and child feeding problems; teaching patients and student nurses, in the latter case laboratory and practical teaching only. On each of the main services there should be adequate instruction in methods, practice under supervision, and opportunity for carrying responsibility.

3. Attendance at selected medical and paediatric lectures; other lectures by non-medical authorities to be arranged.

4. Definite opportunity towards the end of the course for carrying full responsibility of a staff dietitian for from two weeks to a month.

5. Use of a good medical library.

6. One to two weeks vacation should be granted in the middle of the course.

Administration

About one third of the course is devoted to some phase of administration. Food production experience provides an opportunity to work with a great variety of equipment, many types of service, various food cost levels, and many employees. Actual food production and service of various types—for private and ward patients, children, professional and non-professional personnel, and other specialized catering—offers a wealth of experience in administration, scientific menu planning, purchasing of food and equipment, and marketing and budgeting expenses. Kitchen, dining-room, and cafeteria planning, are all part of the intern's training. As approximately one third of the hospital's annual expenditure goes into food service, she must at all times be economy conscious, checking plate and refrigerator waste and even the garbage.

Personnel

Since personnel is such an important part of hospital dietetics, considerable time is devoted to this phase of training. The intern receives practical experience in compiling job specifications, job ana-

lyses, time and duty schedules, and in interviewing applicants.

Sanitation, as it is concerned with the purchase, preparation, distribution and service of food, care and use of equipment, and housekeeping procedures, is particularly emphasized.

Therapeutics

One third of the year's work is devoted to therapeutics in which further instruction and opportunity to apply the knowledge acquired in university are offered. Filling the diet prescription of the doctor and supervising the preparation of and serving the tray would confine the intern to a very limited niche of therapeutic experience. She must also correlate the diet with the medical aspects of the case, having due regard for the emotional factors involved, since with the sick, individual likes and dislikes, habits, and sometimes phobias, are perhaps more marked than in any other field. The patient is visited frequently so that he can make known his wishes. Detailed work on individual patients is needed, with close observation of the results. Dealing with the sick, who for the time are abnormal (especially in eating habits), requires psychology skilfully applied. The intern is a member of a hospital team; the doctor, the nurses, the medical social worker and the dietitian all help the patient get well. The intern works with the doctors on corrective diets and explains the special food requirements to the patient. Each patient is an individual study and results obtained through the proper dietary treatment are very encouraging. The time is past when the workings of the dietary service was obvious only when the patient was served with his three meals a day. It is now a skilful tool in the treatment of the sick and convalescent. Like almost all the other services in hospitals, it is a round-the-clock activity.

Teaching

The sterile technique of preparing infant formulae and adapting menus to children and maternity patients, and teaching them good food habits, is another phase of the work. Results here too are gratifying. Laboratory and practical teaching of student nurses gives the intern poise and confidence. She is reminded that she is a teacher in all phases of her work and unless the patient, nurse, or employee has been effectively taught, the instruction is useless. Some make contributions to the community by teaching classes in normal nutrition, including demonstrations of proper food preparation and evaluation of diets.

Value of Training

The organization of approved courses for dietitians is meeting the present demand of education for action. These fifth year courses are in accord with the socially dynamic concept of education and afford an opportunity to develop the individual so that she will be better fitted to cope with the social and economic problems of today. Ignorance and economic inability to provide proper diet are the principal factors contributing to disease. Therefore education is our first duty in improving nutritional status.

The realm of employment of qualified dietitians is diverse and increasingly extensive. There is an unprecedented demand for more dietitians as more and more fields are opening up, but as yet the supply does not nearly meet the demand.

Dietetics as a profession provides an opportunity to make a useful contribution to the well-being of society through helping to improve the general nutritional status, and raising standards of dietary service. It is an expanding field, one which challenges individual development and offers a gratifying career.

Photo, courtesy Ontario College of Education

Checking a Special Diet Tray

Dietetic Officers Appointed

The following slate of officers was approved at the annual meeting of the Canadian Dietetic Association held at Winnipeg in June, 1949:

President: Margaret Clark, Ottawa;
Pres.-elect: Edith Wark, Toronto;
Vice-pres.: Mary Angus, Ottawa;
Secretary: Helen Murphy, Ottawa;
Treasurer: Dorothy Tyers, Toronto.

◂ Health Care Plans ▸

Sorel, Que., Blue Cross City

The Blue Cross enrolment fever in Quebec province has seen unabated activity in the past seven years and today, although protection has been extended to 450,000 persons, many regions of the 600,000 square mile province have only been partially organized for Blue Cross service.

Such was the case of Sorel, Que., up to May, 1949, when authorities decided to hold a community drive to allow self-employed people to get Blue Cross protection.

And so for four weeks county radio station CJSO was placed at the disposal of the Blue Cross, while the three local newspapers initiated an education program designed to explain Blue Cross to local population.

The newly-built and very modern Arts and Craft school was offered as headquarters, banners were spread across the main streets, posters were placed in the store windows, and all the residents were invited to enrol through a circular letter distributed in every home.

On July 1st, several hundred new members' contracts became effective and as these people benefit from Blue Cross from time to time, it is expected that the great informative campaign started in May in this virgin territory will easily treble present results.

* * * *

Sorel, Ville de la Croix Bleue

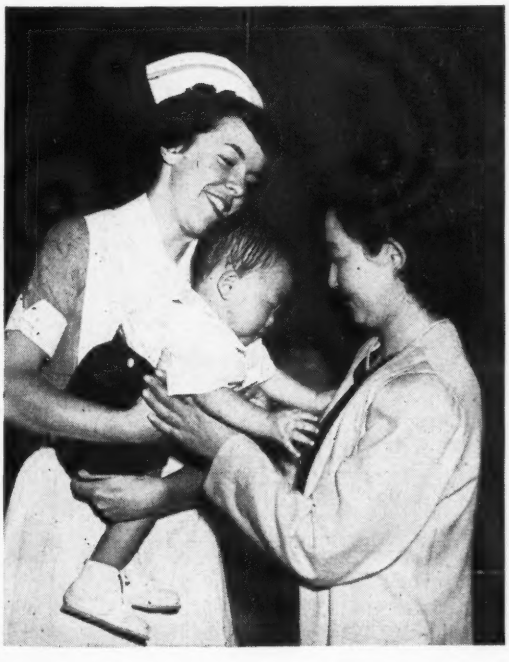
Depuis sept ans que le Plan de la Croix Bleue a été inauguré dans la Province de Québec, il n'a jamais cessé d'être très actif; aujourd'hui, toutefois, bien que 450,000 personnes possèdent la protection de la Croix Bleue, plusieurs régions de cette province de 600,000 milles carrés ne sont que partiellement organisées en vue du service de la Croix Bleue.

Tel était le cas de la région de Sorel au mois de mai 1949, alors que les autorités locales décidèrent de mettre l'épaule à la roue pour fournir aux personnes travaillant à leur propre compte l'opportunité de s'inscrire dans la Croix Bleue.

C'est alors que pendant quatre semaines le poste régional CJSO mit ses services à la disposition de la Croix Bleue, tandis que les trois hebdomadaires locaux lançaient une grande campagne d'information destinéee à renseigner le peuple au sujet des bénéfices de la Croix Bleue.

L'Ecole des Arts et des Métiers, récemment achevée at très moderne, fut offerte comme Quartiers Généraux; des bannières furent suspendues au-dessus des rues principales, des pancartes furent placées dans les vitrines de magasins, et des lettres circulaires furent addressées à chaque chef de famille l'invitant à s'inscrire à la Croix Bleue.

Le ler juillet, les contrats de centaines de nouveaux membres entreront en vigueur. Et à mesure que ces personnes bénéficieront du service de la Croix Bleue, la Croix Bleue sera mieux connue et les résultats présents seront sans doute triplés.



Blue Cross in Ontario reached a significant milestone in its history when the 500,000th patient was hospitalized under the Plan. The nine months old patient, Sammy Oye, is shown in this photograph with his mother, Mrs. Sannosoke Oye at the Hospital for Sick Children, Toronto.

* * * *

Manitoba Blue Cross and Hospitals Sign New Contracts

In Manitoba new contracts have been signed between the Manitoba Blue Cross and all but two hospitals in the province. This brings the total up to 42 member hospitals. St. Joseph's Hospital at Kenora has now signed a contract with the Manitoba Plan as well as with the Ontario Plan, thus giving more adequate service to the many Winnipeg residents who have summer homes at Lake of the Woods and who may require emergency care.

The total number of contracts in force June 30th, 1949, is 114,576 with a total of 271,809 participants. During the first six months of 1949, the Manitoba Plan covered hospital accounts of 20,943 patients with a total of 157,498 days.

* * * *

Toward Better Service

Employee education is recognized by the Ontario Blue Cross Plan as one of its most important projects. Extensive use of bulletin boards has been found a helpful means of disseminating information regarding current activities and developments within the plan, but there still was felt the need for incentive to inspire the staff to learn about the basic procedure of all departments. The

answer was found in the employee questionnaire.

With three cash prizes offered for the most complete and correct answers, a paper, consisting of five questions on each of the plan's five divisions (hospital, records, enrolment, tabulating, and accounting) was handed to each employee with literature outlining benefits, rates, et cetera. A committee composed of the division heads gave a great deal of thought to preparing the questions which would not be too difficult but, at the same time, would bring out each staff member's ability to obtain the required information.

The staff was very enthusiastic in its reception of the questionnaire. Never before did so many at one time take such active interest in what was going on in the other departments. There were a few "boners" such as the one which described Blue Cross as a "non-profitable Plan", and another which said, "Blue Cross is offered at an abnominal rate".

Statistically the project was a success. Of the 353 eligible employees (below the rank of supervisor), 315 or 89 per cent took part; the average mark, out of a possible 100, was 77. Hospital and enrolment division questions were answered best with an average of 17 out of 20. The most difficult problem was with the records division whose questions required more technical knowledge than others. The over-all average for this section was 12 out of 20.

It is planned to conduct another similar project in the early fall. In the words of Mr. D. W. Ogilvie, Deputy Director of the Ontario Blue Cross Plan, "Those of us engaged in Blue Cross work . . . are playing a part in a great movement for the benefit of our neighbours near and far. It is a service that commands our best."

* * * *

Blue Cross Receipts

As an added service to hospitals, Blue Cross in Ontario is assuming the responsibility of mailing the patient's Income Tax Receipt portion of paid accounts directly to the patient. The only change in procedure as far as the hospital is concerned is that, when the account is complete, the patient's copy (No. 4) be left attached to the regular copy (No. 1) for the Blue Cross files and forwarded to the Plan. This will apply to all accounts of which Blue Cross pays any part.

* * * *

Thank You !

To the Executive Secretary,
Canadian Hospital Council.

. . . . Through your good offices, I would like to express the appreciation of the Canadian Blue Cross Plans to the Executive of the Council for their continued interest in the Blue Cross movement.

Yours sincerely,
"E. D. Millican,"
Commissioner,
Canadian Council of
Blue Cross Plans

* * * *

The Blue Cross movement is fast becoming a "way of life" in many communities and can only continue to serve to the fullest extent so long as it has whole-hearted hospital support. The Ontario Plan as a unit of Blue Cross in Canada is grateful to the Canadian Hospital Council for their continued support.

Prompt Service

Hospitals are urged to obtain and send in the subscriber's Blue Cross contract number on all occasions. The contract number is the key to quick service provided the number sent in is the correct one.

New Service To Be Introduced

A new system of reciprocal benefits, which will result in greatly increased coverage of Blue Cross members hospitalized away from their homes, went into effect from coast to coast in the United States on May 1.

Under provisions of the new program, known as the Inter-Plan Service Benefit Bank, a Blue Cross member who is a patient in a hospital outside the area served by his own plan will be treated temporarily as though he were a member of the plan in whose area he receives care. He will be entitled to receive the full service benefits of the local plan, provided by contractual arrangements between the plan and its own local hospitals, rather than the more limited payments heretofore available to subscribers hospitalized out-of-area. The "host" plan will handle the case as though the patient were one of its own members, and will pay its local hospital directly. It will be reimbursed through the "Bank", a national clearing house which will be operated through the Commission.

The program is to be extended to Canada as soon as financial exchange details can be worked out.

* * * *

Net Growth

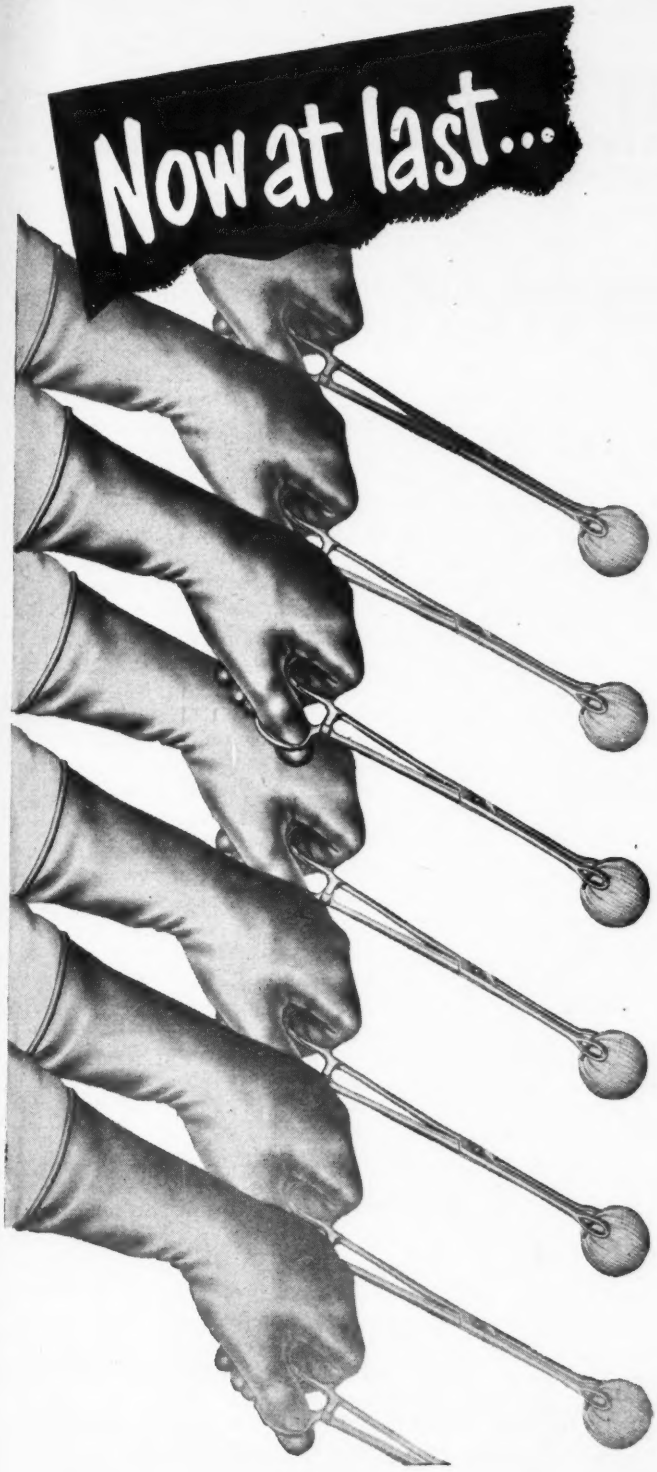
More than 33,700,000 persons in the United States and Canada enrolled in non-profit Blue Cross hospital service plans as of March 31, 1949. The net growth for the first quarter of 1949 was 971,477. In Canada, five Blue Cross Plans serving seven of the Dominion's provinces have enrolled 2,358,598 members, representing 20 per cent of Canada's population.

* * * *

Health Plan Here to Stay

In view of the benefits which have been derived from hospital insurance, it is the opinion of Dr. Hershey, who heads the provincial hospital insurance plan in British Columbia, that it is here to stay. Financial problems as they concern operating costs have disappeared, for under the hospital plan hospitals are assured that their bills will be paid. There has been a marked decrease in the number of patients dependent on charity. Hospital insurance also makes it easier for the doctor to care for his patient in a satisfactory manner, for the cost of service in a hospital is no longer an individual problem. Where a physician might formerly have hesitated in recommending a certain treatment because of its high cost, these services are now available to all for a small premium.

A poet can survive anything but a misprint.—*Oscar Wilde.*



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for every "sponge-stick" use for every department!

The new **Curity Rondic** Sponges are ready-made round or "ball-shaped" sponges like those made by hand in most hospitals in the past. They are made of long-fibre cotton securely covered with fine mesh gauze, and are offered in four convenient sizes.

A "SPONGE-STICK" SPONGE. Rondic Sponges are suitable for use with "sponge-stick" or sponge forceps in any field of surgery. They have been used successfully in abdominal surgery, vaginal and rectal repair, etc. In any situation where a "sponge-stick" is used, **Rondic** Sponges are ready for use.

Other uses are myriad, in all departments. Some of them are:

Tonsil sponge and pack.
Prepping and painting.
Hypo, intravenous or hypodermaclysis wipe.
Any "sponge-stick" use on the floor, dressing carriages, in the laboratory, examining or emergency rooms.

SAVE VALUABLE NURSE-TIME. Rondic Sponges, the first ready-made balltype sponge, release nurses for vital professional duties. The advantages of other ready-made dressings (such as **Curity** Gauze Sponges, **Lisco*** Sponges and **Radiopaque*** Sponges) are known to all hospitals. Now the same advantages may be enjoyed on round sponges.

Ask your **Curity** representative to demonstrate the new **Rondic** Sponges.

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

The necessity to ensure that beds in hospitals are used to the best advantage has led to increased demands upon the domiciliary services. The movement began with the realization that a large proportion of the so-called "chronic sick", if they received a little more nursing and medical attention instead of being regarded as permanent hospital residents, might be restored to a state of health enabling them to return to their own homes. In many cases they may need only such nursing attention as can be provided from time to time in their own homes. The district nursing service is available to them when the condition, in the opinion of the doctor, is sufficiently serious to justify the occupation of the time of a trained nurse.

However, just as the hospitals should be used to the best advantage, so also should there be no waste of the skilled nursing force, especially at a time when the supply is inadequate to meet the justifiable demands. Fortunately spring followed a mild winter without an epidemic, although precedents suggested that there would be one. The anticipation was sufficient for steps to be taken in some areas to strengthen the organization. Members of the British Red Cross Society and the Order of St. John of Jerusalem were enrolled in a closer attachment to the district nursing service so that they were readily available for any emergency. Thus two great organizations have been led to revert to their primary function as auxiliaries to the nursing service. To some extent their activities were drawn in other directions during the war and circumstances which have recalled them to their original aim are all to the good. In some areas there has been an excellent response.

On the other hand, the War produced an admirable organization, the Women's Voluntary Service, which rendered a number of social services especially in those areas affected most by the attacks of the enemy. By the excellence of their work they secured the confidence of the people and have found ample scope for a continuance of their varied activities. They

Health Services in the Home

have been doing particularly good work for the elderly and aged. One service which is especially welcome is known as the "meals on wheels". A hot cooked meal is delivered at the door for a small payment to those who, through ill-health or similar cause, are unable to provide it for themselves. The W.V.S. also undertakes visiting for the purpose of carrying out such duties as might normally be done by a member of the family.

Linked with this catena of services provided by voluntary bodies is the organization of home-helps under the auspices of the local authorities. They are called upon primarily to assist mothers after their confinements although they may also be engaged when there is sickness in the house. This is with a clear understanding that they are not expected nor desired to undertake nursing duties. The home-helps receive a small rate of payment as in most cases they provide wholly unskilled labour, but arrangements are being made to provide a certain amount of training for those willing to receive it and responsible officers are being appointed to supervise the service.

One problem in connection with the old and sick in their own homes still awaits solution. The district nurse must not, and in many cases the home-helps will not, undertake the laundry work, nor are the facilities available for it to be done in the homes of the patient. Particularly is this true in the case of incontinent patients who were formerly in institutions. A further difficulty is that the supply of linen is inadequate though, in the case of those receiving public assistance, sheets can be obtained from the same source. It looks as if the solution can hardly be found through private enterprise as even the hospitals are experiencing a difficulty in placing their contracts. The laundry industry has experienced a great deal of difficulty in maintaining its supply of labour. There is not available the Chinese labour, which, if I remember rightly, contributes so much to the smooth working in Canada of that department of life. It seems as though it will be necessary for the local authorities to supply a service to the homes of the people in the same way as some have already done for the women who can go to the municipal baths and washhouses.

As this letter was being written there appeared in *The Times* a remarkable leading article on medical economics from which a quotation will form a fitting conclusion to this consideration of one aspect of the relationship of domiciliary to hospital services.

"Of all forms of medical care", writes *The Times*, "institutional care

(Concluded on page 88)

Notes on Federal Grants

Crippled Children

Money has been allocated by the federal government to establish a cerebral palsy clinic in Regina and to set up a crippled children's mobile consultation unit to serve small centres throughout Saskatchewan. The federal grant of $14,225 will provide salaries for a physiotherapist, an occupational therapist, four attendants, and a part-time medical supervisor. The grant will also pay for the purchase of physiotherapy and occupational therapy equipment. The mobile consultation clinic will hold clinics and plan treatment, training and rehabilitation programs for crippled children. Part of the grant is to pay for transportation to the clinic of children whose parents cannot afford it.

Construction

Ottawa has approved grants to aid four hospitals in British Columbia. The allotments are as follows: $10,000 for an 18-bed addition to St. Joseph's hospital in Victoria; $1,100 for the extension of the Child Guidance Clinic, Vancouver; a grant of $83,000 towards a 100-bed unit in the provincial mental hospital in New Westminister; and a grant of $314,000 to assist in providing 395 additional beds for mental patients in the Crease Clinic for Psychological Medicine and the Colony Farm Continued Treatment Building, Essondale, B.C.

The new Riverside Memorial Hospital at Turtleford, Sask., which will have a capacity of 19 beds when completed, will receive the full grant per bed. The new Sutton-Lake Johnston Union Hospital at Mossbank, Sask., will receive a federal grant of $10,000, and will accommodate 19 patients; a 17-bed hospital at Delisle has been allocated $4,500; and Canora Union Hospital, which is increasing its bed capacity by 35, will get $35,000. Other sums allocated in the province were $34,000 for the Kindersley Union Hospital, 40 beds; more than $34,000 for the Big River Union Hospital operated by the Red Cross; $8,000 for the new 14-bed hospital at Coronach; $17,300 for the Foam Lake Union Hospital, capacity 31 beds; and $2,300 for a 6-bed hospital at Norquay. The federal government has appropriated $40,000 to help in the cost of constructing the Kamsack Union Hospital on the understanding that the hospital will serve both white and Indian residents of the district.

The new Hospital for Crippled Children in Calgary will receive a grant of $119,000. More than $69,000 has been allocated to help three other hospitals in Alberta. The Claresholm Municipal Hospital will receive $19,000; St. Mary's Hospital in Trochu will receive $14,000 and the Crowsnest Pass Hospital in Blairmore has been granted $36,642.

A grant of $131,900 goes to the new Hôpital du Rédemptuer in Matane, Que. When completed, it will have a capacity of 167 beds. More than $21,000 has been set aside for the new Hotel Dieu Hospital at Sorel, Que.

Funds totalling $4,100 have been earmarked to meet one third of the cost of extending the Sackville Memorial Hospital in New Brunswick. The extension will permit the care of eight extra bed patients. Also being enlarged in the Payzant Memorial Hospital, Windsor, N.S., which is increasing its bed capacity by 45. The federal grant will total more than $45,000.

Four hospitals in Ontario have been allotted more than $240,000. A grant of $151,500 goes to St. John's Convalescent Hospital, Newtonbrook, where 101 beds for the care of convalescent patients are being added through construction of a new pavilion and re-arrangement of present accommodation. A grant of $65,000 has been authorized for the children's section of the Kingston General Hospital. It will contain 65 beds and will replace the present 33-bed section. The Chesley and District Memorial Hospital completed last year, bed capacity 24, has received more than $12,000. The addition to Clinton Public Hospital, providing room for 21 beds and 14 bassinettes, has received a grant of more than $12,000.

Mental Health

Mental health grants totalling more than $864,000 for the Province of Quebec have been made by the federal government. A wide variety of projects will be instituted in Quebec, covering all aspects of the problem of mental health. There will be $315,000 spent in expanding mental health facilities among the French-speaking population of the University of Montreal area, $242,000 among the English-speaking population of the McGill University area, and $306,000 in the Laval University area. Some of the money will go to provide scholarships and bursaries to enable qualified persons to pursue studies in mental health. An expenditure of $45,000 has been approved for financing a child guidance clinic at the Psycho-Social Institute in Three Rivers.

Federal grants of more than $41,000 have been allocated to 6 Ontario hospitals for new medical, surgical and clinical equipment. The Kingston hospital received $8,000; the Ontario Hospital School in Orillia, which serves 2,400 mentally deficient children, $8,550; about $1,500 was allotted to the hospital in Langstaff, while about $4,800 has been earmarked for the Penetanguishene hospital. Fort William will receive $3,500 for the purchase of technical equipment for the hospital and for their travelling mental health clinic. Similar equipment will be obtained for the travelling clinic of the Whitby hospital. Federal grants to this last hospital for this and other improvements amounted to $14,700.

Personnel

A number of awards of Physical Fitness Scholarships to Canadian students have been announced. These awards, worth from $500 to $1,000, will allow the successful candidates to take post-graduate studies in physical fitness and recreation.

Funds from the national health grants have been allotted to 14 per-

sons in New Brunswick and Nova Scotia. The cost of these 14 grants was $12,300. The grants will enable a dietitian from Moncton to take a six-week refresher course at Columbia University, a staff nurse to take a six months post-graduate training in paediatric nursing at the Children's Memorial Hospital in Montreal. Funds have been granted for in-service training for a medical record librarian from the Victoria Public Hospital, Fredericton; to enable two members of the vital statistics staff of the provincial department of Health and Social Services to take a week's training at the Dominion Bureau of Statistics, Ottawa; to enable a staff member from Hotel Dieu de St. Joseph, Bathurst, to take a short course in hospital administration at Laval University, Quebec. A nurse from Miramichi Hospital, Newcastle, is being given a three-months course in surgical nursing at the Montreal General Hospital; two doctors from the provincial mental hospital were given short courses in the interpretation of electroencephalograms at the Montreal Neurological Institute; and assistance will be given to enable a young man to take his master's degree in psychology at the University of Indiana before joining the province's division of mental health.

In Nova Scotia funds have been allocated to assist two doctors to take a year's course in psychiatry at Dalhousie University, while a third doctor will take a year's training at the Toronto Psychiatric Hospital. Money has also been granted to enable the provincial supervisor of physical fitness to take a two-month refresher course in physical education at the University of Springfield.

Public Health

Manitoba has received public health grants totalling more than $11,000 for the execution of three projects. The first is a study of milk processing methods. The second involves the purification, isolation and identification of the Rh hapten, a substance believed to be of value in preventing Rh disease in infants. The third project will involve a study of the physical environment of small schools. In addition, the sum of $7,000 has been approved for the hiring of a hospital building inspector and consultant, who will advise local committees in charge of the construction of hospitals regarding types of construction, quality of workmanship, need for alterations and repairs.

Public health research grants totalling $16,650 have been awarded in the Maritime Provinces. The largest single grant is $7,500 for the University of New Brunswick to finance a study of the nutritional value of New Brunswick-grown farm products.

Three grants amounting to $8,150 are for research work in Nova Scotia. Dalhousie University will launch an investigation into the effects of early ambulation in pregnancy. A second project is an investigation into the merits of BCG vaccination for tuberculosis, the duration of protection, the best mode of administration, and the practical problems involved in an extensive vaccination program in the field. A third project is a study of the level of Vitamin D in the diet of children from two to five years of age in relation to the rate of calcification.

In Prince Edward Island a study will be made of the incidence and significance of paracolon bacilli in water supplies.

Tuberculosis

At the request of Nova Scotia Department of Health, the federal government has allocated more than $84,000 for the equipping and operation of the Point Edward hospital, Westmount, Cape Breton. Included in the equipment purchased was modern x-ray and scientific apparatus to make available the most modern treatment services for tuberculosis.

Appropriation of funds for equipment for Victoria General Hospital, Halifax, has also been made. The grant will cover a fluoroscope for the chest clinic and special operating room equipment to be used for lobotomies.

Total Grants Allocated

The Hon. Paul Martin has announced that in the first two and a half months of the fiscal year, more than one third of the national health grants have been allocated. Out of a total of $31,000,000, more than $12,431,000 have been appropriated. Quebec has spent the largest sum so far, with $5,299,000 allotted. Approved projects in other provinces total as follows: Newfoundland $19,779; Prince Edward Island $180,232; New Brunswick $290,331; Nova Scotia $263,967; Ontario $2,891,359; Manitoba $779,248; Saskatchewan $988,177; Alberta $1,116,348; British Columbia $376,908. Since the first request was received under the national health program last August allocations of more than $27,000,000 have been made and more than a thousand health improvement projects have been approved.

25 Years Ago

August, 1924

By unanimous vote the Canadian National Association of Trained Nurses, meeting in Hamilton, adopted a resolution calling for a ten-hour day for nurses. "It was argued that ten hours is long enough for any nurse to work." Miss Jean E. Brown of Toronto was re-elected president; Miss Kate Matheson of Toronto, 1st vice-president; Miss M. Hersey, Montreal, 2nd vice-president; Miss M. F. Gray, Regina, honorary secretary; and Miss Mary Shaw, Quebec, honorary treasurer.

The Toronto Red Cross established a 25-bed soldiers' out-post hospital on Toronto Island at a cost of approximately $17,000.

Preliminary work had commenced on the construction of the $480,000 provincial sanatorium in Saskatoon.

Contracts were let for the new $1,000,000 St. Sacrament Hospital on Saint Foye Road, Quebec City. The building was planned to accommodate some 400 patients.

The man who idly sits and thinks,
May sow a nobler crop than corn,
For thoughts are seeds of future deeds,
And when God thought—the world was born. —*Harry Romaine.*

Provincial Notes

British Columbia

NEW WESTMINSTER. When completed the new wing of the Royal Columbian Hospital will provide the hospital space needed for the community. The next problem will be the furnishing of this wing. Because of the sharp increase in building costs, all available funds have been used for construction purpose. It is estimated that it will cost $72,000 to furnish the service departments and the wards.

Alberta

FORT VERMILION. Traders, trappers, farmers and business people gathered on June 2 for the official opening of the new St. Theresa Hospital. The $100,000 hospital is furnished with modern x-ray and operating room equipment and has a capacity of 16 beds.

* * * *

RIMBEY. St. Paul's Hospital at Bentley has been purchased for $65,000 by the town of Rimbey with the co-operation of the municipalities of Lacombe, Ponoka, and Last West. This building is to be used as a chronic and convalescent hospital. Plans are being made for alterations, a elevator has been purchased, and accommodation for 35 to 40 patients is expected to be ready by autumn.

* * * *

TABER. The recommendation that the nurses in Taber hospital, who are now housed in hospital rooms, be provided with a separate building has been approved by the director of the Health Survey Committee. This addition will provide the hospital itself with twenty more beds and, at a grant of $1,000 per bed, will make $20,000 available for improving the hospital facilities.

Saskatchewan

BIG RIVER. A meeting was held recently in Big River to discuss plans for erecting a nurses' home. Members of the local Red Cross, the Red Cross Hospital Auxiliary, and the Big River Union Hospital Board were present. Plans were made for the village and district to raise $5,000 and the Red Cross is expected to contribute $5,000 towards the cost.

* * * *

MAIDSTONE. Construction on the new Maidstone hospital began on June 7. The site was dedicated by Mr. D. Brown, deputy reeve. The work is expected to progress rapidly and it is hoped that the building will be closed in before fall.

* * * *

TURTLEFORD.. The staff of the Turtleford and District Hospital raised $800 at a recent dance, which they held in aid of the Riverside Memorial Union Hospital, now under construction.

Manitoba

SHOAL LAKE. Citizens of Shoal Lake and the surrounding districts voted in a bylaw to raise $94,000 to set up the Shoal Lake hospital district. This money will provide a 20-bed hospital in Shoal Lake itself, equipped with a nursery, an operating room, X-ray and laboratory diagnostic facilities, and additional space for other health services. It will also allow for a 10-bed nursing unit at Rossburn, and a unit of three or four beds at Elphinstone.

* * * *

WINKLER. The Bethel Hospital Society have prepared for publication in year-book form the reports of the various auxiliary committees associated with Bethel General Hospital. The book will also contain much historical material dealing with the organization of the hospital a dozen years ago.

Ontario

LONDON. The district administrator of the Department of Veterans' Affairs has announced that a long-range project to replace old buildings at Westminister Hospital will begin this fall. When completed, the new hospital will be H-shaped. The east side of the "H" will be five storeys high and contain dining-rooms, kitchen, wards for 300 beds, and on the top floor, operating and x-ray rooms. The west wing will be three storeys high and contain clinics and admission and discharge departments. The joining cross wing will have administration offices, laboratories, and doctors' quarters.

* * * *

OSHAWA. At the last regular meeting of the Board of the Oshawa General Hospital, an "exploratory committee" was set up to study the needs of the hospital. The committee will consult with a committee of the medical staff and study trends in hospitals here and elsewhere. Not only the necessity of increased bed accommodation will be under consideration, but also the necessity of providing adequate services to keep pace with this increased capacity.

* * * *

OTTAWA. The Civic Hospital trustees have unanimously approved a recommendation that immediate action be taken to expand the pathological building by the construction of five additional floors. The General hospital, St. Vincent de Paul Hospital, and the Perley Home are contemplating additions which would provide 450 to 650 new beds, and if the Civic Hospital project should be carried out, there will be from 750 to 950 new beds available.

* * * *

ST. THOMAS. Plans for the St. Thomas-Elgin General Hospital are progressing. Sketches of a suggested hospital structure, built in three wings, four storeys in height, and with provision for two more floors, if and when required, have been shown by the architect, Mr. James Govan, to members of the joint hospital investigation committee of the city and the county. Mr. Govan estimated the cost at $2,500,000.

* * * *

SARNIA. At a recent meeting of the Hospital Board of Commissioners, a detailed report from the Ontario

(Concluded on page 86)

First Line of Pyrogen Defence

You know that the patient is protected against pyrexial reactions, that a militant crew like the one above has served as a first line of pyrogen defense when you use Abbott Intravenous Solutions. You know, too, that further exacting tests have been made for sterility and content. In fact, you know that when intravenous solutions bear the Abbott label, they are as good as intravenous solutions can possibly be made. And you eliminate another source of worry about pyrogens and sterility when you use the new disposable Venopak* equipment — the economical set that comes ready to be used once, then thrown away. The safety, the convenience and the saving in processing and personnel time are worth investigating, worth bringing up at the next staff meeting. Ask your Abbott representative for a demonstration.

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Schools for Laboratory Technologists — Basis of Approval in Canada

THE following standards, set up by the C.M.A. Committee on Approval of Schools for Laboratory Technologists, are listed here for the information of hospital authorities who may be desirous of organizing such schools. "Application for Approval" forms may be obtained by writing to the Canadian Medical Association, 135 St. Clair Ave., West, Toronto.

1. Approval of schools for laboratory technologists in Canada shall be conducted by a Committee of the Canadian Medical Association appointed for this purpose and working in co-operation with the Canadian Society of Laboratory Technologists.

2. Schools may be located in adequately organized departments of pathology associated with public hospitals and in university and governmental or municipal laboratories. Hospitals, in which such laboratories are located, if general hospitals, must have a capacity of at least 200 beds, excluding bassinets, and an average daily census of 125. If the hospital be of a specialized nature, the material submitted to the laboratory must be adequate and sufficiently varied, in the opinion of the Committee, to warrant recognition of the school; the same stipulation applies with respect to governmental, municipal or university laboratories. A university affiliation by a hospital or other laboratory is recommended in order to obtain the advantage of instructional facilities in scientific subjects.

3. The director of the laboratory must be a graduate of a recognized medical school and be a clinical pathologist of recognized standing. He shall be in daily attendance for a sufficient time to supervise properly the laboratory work and teaching.

4. The laboratory shall have a technical staff consisting of a sufficient number of registered laboratory technologists who are capable of carrying out the practical instruction of the student.

5. Responsibility for the courses of training for laboratory technologists shall rest jointly with the pathologist in charge and with the hospital administration, if the school be in a hospital. The director of the laboratory shall be responsible for the actual teaching and instruction of the student.

6. The enrolment of the students at any one time shall not exceed one student to each full-time qualified member of the technical staff of the laboratory.

7. The facilities of the laboratory shall be sufficient to meet fully the requirements for adequate service to patients and for the instruction of students in the fields covered.

Schools undertaking general instruction to students must have adequate and modern equipment in all laboratory fields. There should be adequate variety of museum and other specimens and examples.

8. Educational requirements for admission of students for training shall be those demanded by the Canadian Society of Laboratory Technologists which are as follows:

Senior Matriculation or the equivalent educational standing in the various provinces. Two science subjects are required, one of which must be chemistry. Educational standing in the various provinces:

British Columbia — Senior Matriculation.

Alberta—Grade XII.

Saskatchewan—Grade XII.

Manitoba—Grade XII.

Ontario—Senior or Honour Matriculation or Grade XIII.

Quebec — Senior High School Leaving Certificate or Senior Matriculation of McGill.

New Brunswick—Senior Matriculation or Grade XII.

Nova Scotia—Grade XII.

Prince Edward Island — 1st Class License Certificate of the Department of Education or 3rd Year Certificate of Prince of Wales College.

Newfoundland—Senior Associate Diploma.

A transcript of educational credits must be submitted with registration forms.

9. Two types of training shall be recognized; (a) general training, and (b) specialized training. A school may be approved for either or both types of training. The course of training for either a general certificate or one in a special field shall extend over a period of at least 12 months. (See paragraph 2.)

(a) General training (Certificate "A") shall include training in the technique of haematology, bacteriology, medical zoology, histology, pathological chemistry, and serology. The course shall consist preferably of a rotating or departmentalized service with a minimum of 300 laboratory and sufficient didactic hours in each period of service to give the student a thorough grounding in the principles and technique of each subject studied.

The instruction shall include:

1. **Didactic instruction.**
2. **Practical demonstrations.**
3. **Text assignments and reading courses.**
4. **Periodic examinations.**
5. **Practice periods and performances of tests under supervision.**
6. **Development of responsibility.**

(b) Special training (Certificate "B") shall be in one or more of the following: histology, serology, bacteriology, haemotology, or pathological chemistry. Recognition of other subjects for specialty certification shall be at the discretion of the Committee on Approval.

No candidate may qualify for more than one specialty certificate ("B") in any one year.

10. Careful records shall be maintained of the instruction given, work done by the individual student, and of the standing of the student. Of importance are observations respecting the accuracy,

(Concluded on page 88)

Here and There

Cholera at Kingston in 1832

(The following excerpts are from "Trifles from my Port-folio", by Dr. Walter Henry, staff surgeon, stationed at Kingston, Ont., in 1832.)

AS soon as it was known that malignant cholera had really appeared in Quebec, it was plain enough that it would find its way to the shores of Lake Ontario. . . We first had the barracks and hospitals most carefully cleaned and whitewashed; the duties and fatigues of the soldiers were lightened as much as possible, and they were daily inspected with great care by their medical officers. The canteen was placed under vigilant supervision and preparations were made to isolate the barracks and to remove the married soldiers resident in the town, with their families, to a camp on the other side of the bay. . .

Although the cholera raged in the town (Kingston) for the next fortnight, we had no case in the regiment till the 4th July, when two grenadiers were attacked with frightful spasms — I was sent for on the instant — bled them both largely, and they recovered. Ten other men of the regiment were taken ill and treated in the same way; the agonizing cramps yielded to the early and copious bleeding, as to a charm, and they also all recovered.

Encouraged by the result of these, and several similar instances amongst the poor people of the town, I began vainly to imagine that this plan of treatment would be generally successful and wrote confidently to this effect to Dr. Skey; but I was soon to be undeceived. Three men and a woman, of the 66th, were attacked the same night. I saw them immediately; and the symptoms being the same to all appearance, they were bled like the others, and all died within twelve hours of the first attack. . .

The fact is, I believe that we had two different diseases, confounded together under the common name of cholera, to contend with; one of these maladies having very much the character of tetanus, or locked-jaw. . . .

We all heard wonderful accounts of the effects of transfusion of saline fluid into the veins, and Dr. Sampson, the principal practitioner in Kingston and a man of talent, was determined, as well as myself, to give it a fair trial.

We used it in twenty bad cases, but unsuccessfully in all—though the first effect in every instance was the apparent restoration of the powers of life; and in one remarkable case of a poor emigrant from Yorkshire, life was protracted seven days by constant pumping. Here the man almost instantaneously recovered voice, strength, colour, and appetite; and Sampson and myself, seeing this miraculous change, almost believed we had discovered the new elixir of life in the humble shape of salt and water. . .

During the prevalence of the disease it seemed to me that a number of errors in diet were generally entertained and acted on in our little community. Because unripe fruit, or excess in its use does mischief, all fruit was now proscribed by common opinion; and vegetables of every description were placed under the same ban, so that the gardeners saw their finest productions rotting unsaleable. This was folly; for the stomach was more likely to suffer than to benefit from the want of its accustomed pabulum of mixed animal and vegetable substances. It was proper to live temperately—to avoid supper eating, or eating late in the day—as eight-tenths of the attacks came on in the night—to eschew excesses of all kinds—but, above all, to be fearless and place confidence in Providence.

If, amidst so much distress, ludicrous ideas could be entertained, there was enough to excite them on this subject of abstinence from vegetables. Huge Irishmen who had sucked in the national root with their mother's milk, and lived on it all their lives, now shrank from a potato as poison. I heard a respectable and intelligent gentleman confess that he was tempted by the attractive appearance of a dish of green pease, and ate *one* pea, but he felt uncomfortable afterwards and was sure it had disagreed with him.

The disease ceased entirely and the usual intercourse was restored between the Garrison and the Town in the middle of October.

A Gallop of Cure

There is a little old walled town called Galisteo, situated nearly equidistant between Coria and Placentia, where two of the regiments of our Brigade were quartered during the early spring months.* At this place I was attacked by my old enemy the Tertian ague, which I dosed in the regular way with all the usual remedies for a fortnight —but all in vain—at twelve o'clock every second day my teeth began to chatter. Thinks I to myself—this open attack on the enemy will never do—let us try a manoeuvre. Accordingly, at half-past eleven I prepared a tumbler of hot spiced wine — ordered my horse to the door — got into the saddle and drank it off, and then proceeded in a canter over the extensive plains in the neighbourhood. When it approached twelve, although the sun was powerful, I could feel the ague-fiend's cold fingers grasping my loins—I then put spurs to *Liberdade*—pushed him into a full gallop—and at length, by dint of perseverance and good management, I fairly distanced my villainous pursuer. I tried this plan with equal success the next time, and on the return of the third Tertian period, was delighted to find that at twelve o'clock my feelings continued comfortable—my spine did not turn into an icicle, nor my grinders commence their former hornpipes.

**During the Spanish Campaign in the Napoleonic War. An excerpt from "Trifles from my Port-folio", by Dr. Walter Henry.*

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... *in Pure, Crystalline Form*

VITAMIN B_{12}, isolated in the Merck Research Laboratories, is available as Cobione* (Crystalline Vitamin B_{12} Merck). Cobione has been proved by clinical studies to exert high hematopoietic activity in the treatment of

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COBIONE:

- **A pure, crystalline compound of extremely high potency.**
- **Effective in extremely low doses, because of its high potency.**
- **May be administered subcutaneously or intramuscularly in precise dosage, because it is a pure, crystalline compound.**
- **No known toxicity in recommended dosages.**
- **Supplied in ampuls of 1 cc. of saline solution of Cobione, each cc. containing 15 micrograms of Crystalline Vitamin B_{12}.**

Literature available on request.

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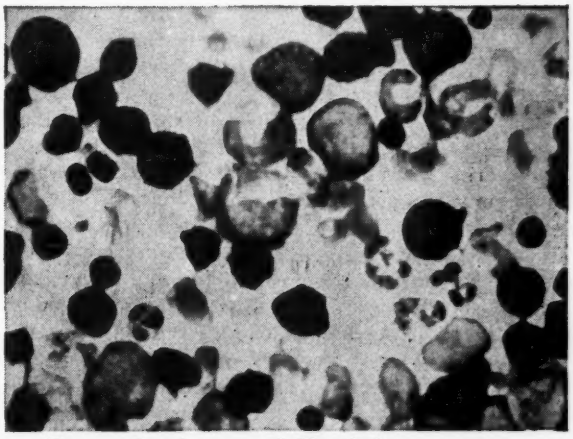
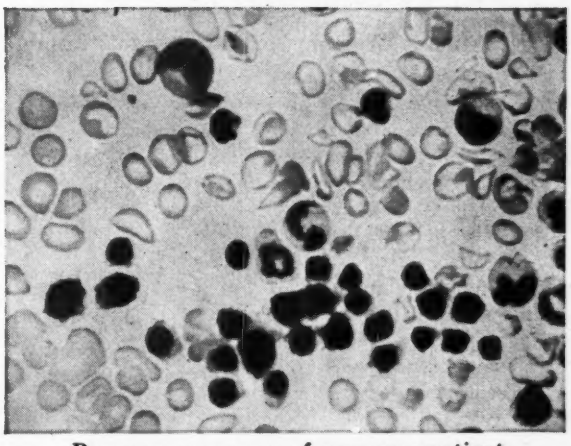


Smear showing megaloblastic bone marrow of patient with pernicious anemia before treatment with Cobione



Bone-marrow smear from same patient ninety hours after a single injection of 0.025 mg. of Cobione

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VALLEYFIELD

Medical Social Service

(Concluded from page 30)

popular belief, the social worker does not admonish and advise but, through her understanding of behaviour, helps the person to a clearer conception of his problem and offers such support as she can through available resources.

Training Required

Preparation for social work requires university graduation followed by a two year post-graduate course in a recognized school of social work. The medical social worker, in addition to learning the basic skills of social work, takes additional courses in medical information. She learns the meaning of diagnosis and treatment to a patient, in terms of dependency, earning capacity, and feelings of adequacy in relation to his responsibilities. She is neither a doctor nor a nurse and does not require detailed knowledge of disease in order to work intelligently and effectively. She acquires information designed to make her adjustment to the hospital setting as easy as possible both for herself and for those with whom she works. She receives practical experience throughout her course by spending approximately two days weekly doing supervised field work in a social agency approved by the school. During her second year her field work experience is acquired in the medical social service department of a hospital. She is expected to complete a thesis based on original research in medical social service. On completion of her course she receives a Master's degree.

The major function of medical social service is the practice of medical social case work. The department however, may and should develop other activities which will enhance the service to the patient, the hospital and the community. Such activities depend on sound and continuous social case work practice. They include:

1. Participation in
   - (a) program planning and policy formation;
   - (b) the educational program for professional personnel;
   - (c) the development of social and health programs in the community;
2. Medical social research.

Due to her training and experience, the medical social worker has a responsibility to interpret, within and without the institution, to lay and professional people, the feelings and the needs of patients. With her knowledge of the personal, social, economic and emotional difficulties with which patients are faced and which handicap medical treatment and rehabilitation, she is well equipped to participate in discussion and planning which will lead to the provision of improved resources within the hospital and the community.

Conclusion

Medical social service is not a luxury, it is a necessary part of medical care. In spite of the fact that such a service involves financial outlay for the hospital, it is an economy. It is an economy not only to the patient, the doctor, and the hospital, but to the community as a whole. It helps the patient to make optimum use of medical care and to rehabilitate himself within his limitations. It helps the doctor to use his skill in the most constructive manner in relation to each individual whom he treats. It assures the hospital administrator of a more effective use of hospital facilities. It serves the community by indicating the need for and helping to develop essential resources. It returns to the community citizens who, in spite of physical handicap, may yet lead happy and useful lives.

Hospital in New South Wales Has Brilliant Woman Medical Administrator

Dr. Mary Puckey is the only woman in Australia to combine the posts of chief executive officer and medical superintendent of a hospital. She holds these posts at the Rachel Forster Hospital in Sidney, New South Wales. Dr. Puckey is a graduate of the University of Sidney and took her Diploma of Public Health in 1925. After training in hospital administration, she accepted her present position at the Rachel Forster Hospital in 1941. This hospital, run entirely by women for the benefit of women and children, was started in 1922 by Dr. Lucy Gullett, one of Australia's first women medical graduates, to give free treatment to needy women and children and, at the same time, to serve as a training centre for women doctors.

The present institution is subsidized as a public hospital by the government of New South Wales. It has a capacity of 114 beds and a unit for convalescents which will accommodate 123 patients. As of this year a nurse training school has been opened with 50 students enrolled. There are 16 women interns on the staff. The hospital has a busy medical social service department and plans are underway to build a new and modern out-patient division as well as a large children's section.

Dr. Puckey who is a brilliant physician as well as a capable executive keeps in close touch with all departments and is absorbed in plans for the further development of this splendid institution.—*Courtesy Office of the High Commissioner for Australia, Ottawa.*

Dr. Mary Puckey

He wrapped himself in quotations —as a beggar would enfold himself in the purple of Emperors.—*Rudyard Kipling.*

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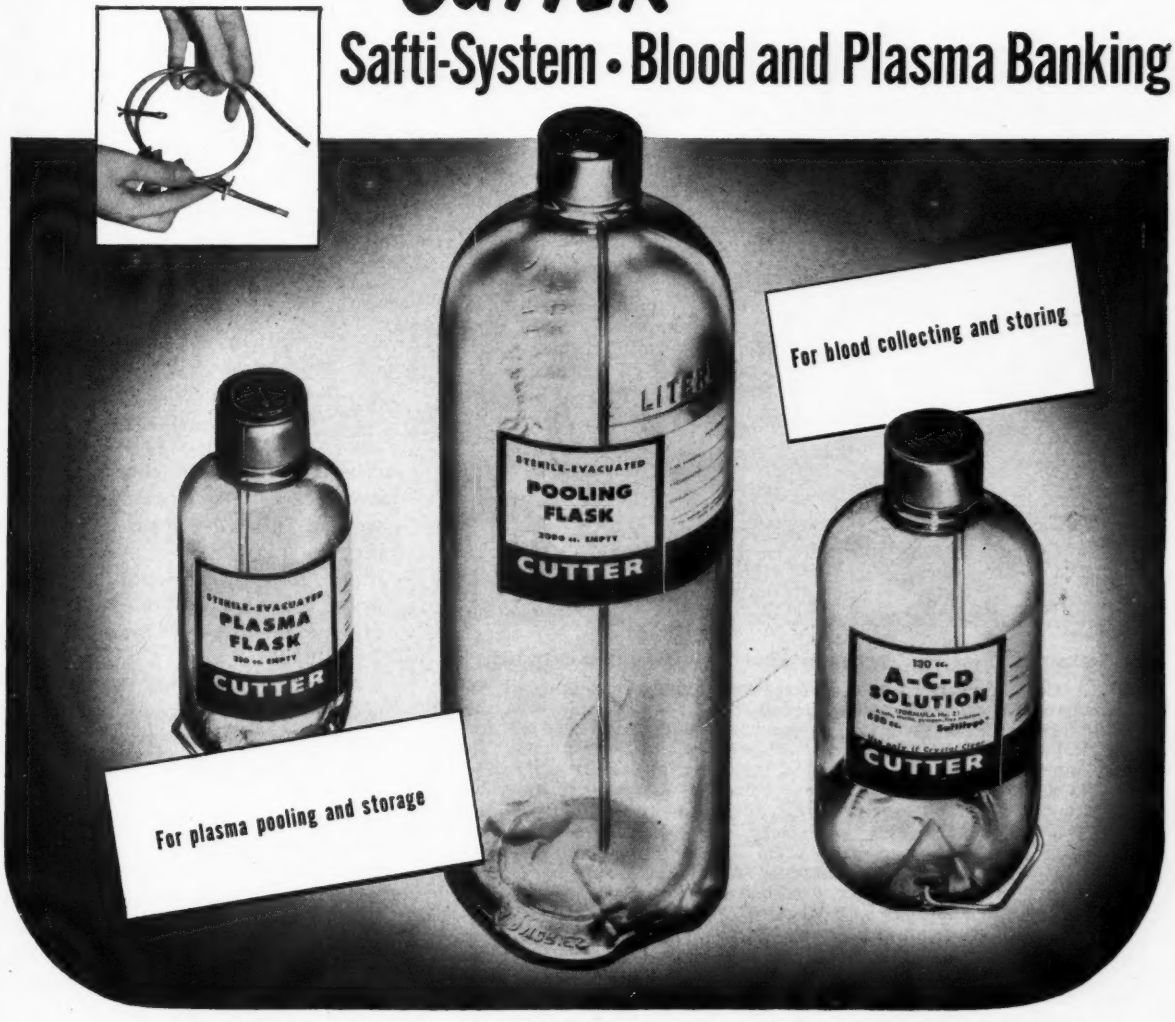

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Health Grants Program

(Continued from page 28)

ments for the various types of hospitals is as follows:

Tuberculosis	$13,528,000
Mental	6,326,000
Chronic	2,152,000
Active treatment	17,894,000
Total	$39,900,000

The total estimated cost of all this construction exceeds $93,000,000 so that tax funds from the provinces and federal government account for about 43 per cent of the total cost of construction.

It is interesting to note that indications point to a reduction in construction costs. In several instances we know of bids that have been as much as 25 per cent below the architect's estimates. Moreover *firm* bids can once more be obtained—something that was not possible a year ago. All in all there is reason to feel that the prospects in all phases of this field look brighter than they have for years.

Provisions Under New Orders-in-Council

The new Orders-in-Council governing the national health program for the present fiscal year have been prepared and brought into operation. They follow the same pattern as the Orders under which the grants were applied in the previous year. However there are some small differences which are of interest.

In administering the hospital construction grant it was found, in at least one part of Canada, that the province concerned was not prepared to match the federal grant dollar for dollar. This particular province had for several years been paying lump sum grants to assist communities in the construction of hospitals, the amount of the grant depending on the fiscal need of the district, taking into consideration how much money it could raise by taxation, private subscription, et cetera. The province did not wish to increase its contribution to more than what had already been granted and that referred particularly, of course, to projects which were under construction as at April 1, 1948.

A strictly legal interpretation of the Order-in-Council for 1948-49, based on its actual wording, would have meant that if a provincial government did not match the federal grant to which the Department thought a particular hospital was entitled, the federal department would then be unable to make any payment whatsoever. This, of course, would be a completely undesirable situation. Consequently, to avoid this dilemma a clause was added to the new hospital construction grant making it possible for a province, in agreement with the municipalities or authorities concerned with the construction of a hospital or nursing unit, to request a federal contribution of less than the amount to which it would normally be entitled. The Minister may now authorize payment to the province of such amount as it requests in lieu of the amount to which it would be actually entitled under the Order-in-Council.

In respect to other national health grants there had been considerable doubt in the minds of our Treasury officials as to whether we had authority to provide training under any of the grants other than the professional training grant. As we had already been making such payments in the year 1948-49, it was thought that the Orders-in-Council should be changed to make provision accordingly. Now professional training can be authorized under the crippled children's grant, the venereal disease control grant, the mental health grant, the tuberculosis control grant, and the cancer control grant, in addition to the professional training grant itself. This should afford the Department plenty of leeway and provide suffi-

(Concluded on page 64)

Saskatoon Hospital Experiences First Television Demonstration

A most interesting feature of the 80th annual convention of the Canadian Medical Association, held in Saskatoon in June, was the presentation of nine televised programs demonstrating medical and surgical techniques. The programs, sponsored by the Squibb Pharmaceutical Company and the first of their kind in Canada, originated in the Saskatoon City Hospital and were viewed one mile away by 1,000 doctors from all over Canada in the convention hotel.

The largest operating room was equipped with a television camera suspended from a metal beam and a doctors' library served as a control room. A general duty room became an improvised studio and a conference room was rearranged to accommodate the hospital staff and to serve as a "theatre" for the programs.

In the above picture, taken on the roof of the Saskatoon City Hospital, a television engineer explains the finer points of television to E. V. Walshaw, acting superintendent of the hospital. The huge dish-like instrument houses the transmitter, from which the picture signal is sent along a beam through the air to a receiver atop the hotel.

Health Grants Program

(Concluded from page 62)

cient funds for training all types of personnel.

Advantages to Hospitals

It has been suggested that there may be disadvantages as well as advantages in the national health program, but it should be emphasized that the advantages so outnumber the disadvantages that the latter can be disregarded almost entirely. Under the present high cost of hospital construction, $1,000 or $1,500 a bed does not appear to be a very substantial contribution. Matched by a province, however, it does form an appreciable sum of money which, now that there are ten provinces under the program, will amount to some $132,000,000 over the first five years of the operation of the plan.

It may well be that the provinces will be unable to make the desired use of this money under the present terms of the Orders-in-Council. If so there may be reason for considering changes in the terms of the Orders. This will necessitate appropriate changes in the *wording* of the Estimates.

Nearly all hospitals have received some assistance in some manner under the various national health grants, in addition to what they have derived from the hospital construction grant itself. For instance, under the tuberculosis control grant alone, as at June 13, a total of $1,215,475 has been approved to establish within general hospitals the necessary type of x-ray apparatus to provide for routine examination of hospital admissions. Of this amount over three-quarters of a million dollars has been spent. In many hospitals equipment has been purchased for laboratory services in order that these facilities may be employed for public health purposes. Provision has also been made in many hospitals for installing diagnostic and therapeutic x-ray equipment for the detection and treatment of cancer. Under the professional training grant, many hospitals have been able to extend training to members of their staffs to fit them better for supervisory positions or for the instruction of nurses in training.

A great many new sanatoria across the Dominion have been completely equipped with all the scientific apparatus they require. In some instances, in the larger institutions, this has run into as much as $150,000. The same applies to mental hospitals. Altogether then, hospitals have been recipients of large amounts from the various grants.

Uniform Accounting System

The need is growing urgent for some sort of uniform accounting system for all hospitals across Canada. This is desirable not only from the standpoint of the hospital itself, but is essential at the federal level if we are ever going to obtain some uniform figures in respect to hospital costs.

Because of the growing public demand for the provision of prepaid hospital care, stimulated by the great success of such arrangements as the Blue Cross plan, two provinces have already embarked upon pre-paid hospital plans on their own initiative. It is more than likely that other provinces will follow suit. This makes it imperative that the provinces should be able to estimate accurately hospital costs, in order that rates of payment can be fixed which will be equitable not only to the hospitals which provide the services, but also to the people who are going to pay for them.

Conclusion

In conclusion I would like to express my deep appreciation to all those working in the health field across Canada who have shown such complete co-operation with the Department of National Health and Welfare in the administration of the national health grants. In this connection, we are humbly pleased to mention the Canadian Hospital Council, the Canadian Medical Association, and particularly the provincial health officers and their staffs. The successful progress of the program fully justifies my personal belief that if provincial health departments are given the proper tools with which to work, they can and will do the job of providing the people of Canada with the health services they should have.

Being responsible for the administration of the national health program, under the direction of the Hon. Paul Martin and his Deputy, Dr. Cameron, has been a wonderful experience for me. I have had an unparalleled opportunity of watching the unfolding of a program of public health activities the like of which has never before been seen in Canada or anywhere else on this continent.

In this advancing crusade all agencies, both public and voluntary, have their respective roles to play. I know that the people of Canada can count on the Canadian Hospital Council and its provincial counterparts to continue undiminished their contributions to the hospital field so that the specialized knowledge they possess will be at the disposal of the nation, as they work in fullest co-operation with other agencies to ensure adequate hospital service to all our citizens.

T.G.H. Appointment

H. S. Doyle, M.D., D.P.H.

Dr. H. S. Doyle, who was formerly Director of Communicable Disease Division, Department of Public Health, Saskatchewan, has been appointed to the position of Assistant Superintendent Medical at the Toronto General Hospital and assumed his new duties last month. He succeeds Dr. Charles Parker who resigned earlier this year.

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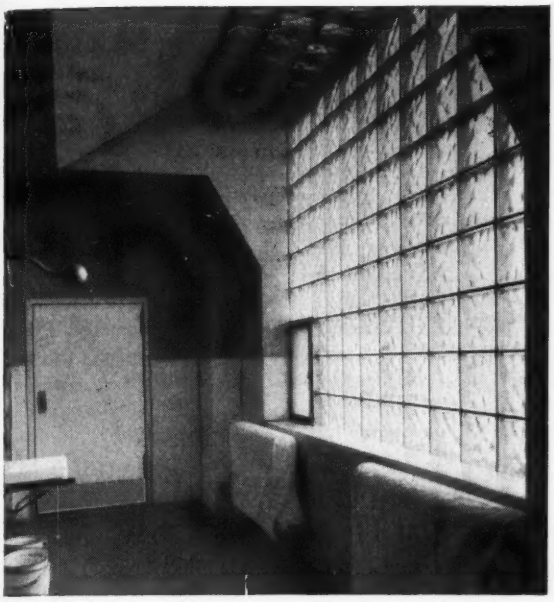

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New Habit-Forming Drugs

Many new synthetic anaesthetics and analgesic drugs, for use as substitutes for morphine, have been evolved in the past few years. The question now arises whether these drugs will prove to be habit-forming and thus belong to the group of substances governed by the Conventions of 1925 and 1931, or whether, on the other hand, as substances "which are compounded and which in practice preclude the recovery of the said drugs", they may be exempted from such control. The WHO Expert Committee on Habit-forming Drugs, at its first session in Geneva, 24-29 January, was required to make recommendations on this question and to consider requests, received from governments during recent years, for the exemption from control of several types of drugs.

After considering the reports submitted by experts on each of the drugs under examination, the committee recommended that the following substances and groups of substances be brought under the existing international conventions on account of their habit-forming potentialities:

Valbine. This drug is subject to control on account of its content of dihydrooxycodeinone hydrochloride, of the possibility of recovering this alkaloid from the preparation, and of the presence of a barbiturate, which constitutes an additional habit-forming danger.

Metopon hydrochloride (methyldihydromorphinone hydrochloride). Chemically metopon hydrochloride is a morphine derivative; it is a more powerful analgesic than morphine and has approximately the same properties as regards tolerance and habit-forming.

Acetylcodone (acetyldihydrocodeine hydrochloride). Although no specific information was available on its habit-forming properties, the committee considered that this substance should be placed under control because it is convertible to dihydrocodeine, which in turn is convertible to dihydromorphine, a habit-forming drug. These considerations apply equally to other esters of dihydrocodeine and their salts, and to dihydrocodeine and its salts.

Dolantin (Demerol, Pethidine, Piridosal) (1-methyl-4 - phenyl - piperidine-4-carboxylic acid ethyl ester). Because of the powerful habit-forming properties of this substance and its salts, the committee recommended that they should be governed by the provisions of the 1931 Conventions. The committee considered that the other substances of the Dolantin type (Bemidone, Keto-Bemidone, NU-1196, NU-1779), should be noted for appropriate action when the 1948 protocol comes into force.

Methadone (Amidone). The same provisions should apply to this drug and substances of similar chemical structure on account of their habit-forming properties.

Precautionary measures with regard to synthetic substances. The committee was of the opinion that governments should watch with extreme care synthetic drugs of similar structure to those already examined which may prove to have habit-forming properties.

Heroin (diacetylmorphine). The committee expressed its alarm that although the dangerous nature of heroin is now universally recognized, consumption of this drug has increased considerably in certain countries. Heroin is known to be more toxic than morphine, as its analgesic effect is from four to eight times more powerful. Its effect on the nervous system is much greater and 0.007 g. of heroin is sufficient to induce respiratory paralysis. Over the last fifty years, heroin has caused great havoc in the world. It is strange to note that in some countries heroin continues to be widely prescribed, while others have completely ceased to use it. The committee was of the opinion that further information was urgently needed on the reasons for the continued use of considerable quantities of heroin in some countries.

Morphan. The committee was informed that German and American chemists have produced, by direct synthesis, a compound known as Morphan, in which the structure of the naturally occurring morphine alkaloid has been very nearly attained. This difficult synthesis is not at the moment a commercial possibility, but the synthesis of other compounds related to morphine is going forward and the progress of this research should be watched very carefully.

Finally, the committee was impressed by the variety of names given to the same drug by different manufacturers. Indeed, to avoid ambiguity, it had been necessary to give the full chemical formula of these substances. The committee drew attention to the advantages which would result if each substance could be given a recognized name by some authoritative, and preferably international, body.

Excerpts from a report in "Chronicle of World Health Organization", Feb., 1949.

Annual Joint Convention of Montreal and Quebec Conferences

The second general convention of the Catholic Hospitals of the province of Quebec was held in Montreal from June 27th to June 29th. Three thousand delegates were present. They represented not only the Catholic hospitals of Quebec, but many in Ontario, New England, other sections of the United States, and New Brunswick. The theme of the convention was "At the Patient's Service". The program dealt with every practical aspect of hospitals and their problems, as well as dealing in detail with the scientific and professional developments of the various departments of the hospital. Besides lectures, there were 121 exhibits displaying everything from floor polishers to electro-shock equipment.

Nursing Survey Essential

Let us find out what Canadians need in the way of nursing service and the best way to give it to them. This can be done only by a careful scientific survey on a national basis. When this information is gathered each province should plan how best to meet the needs within its own boundaries. This means that the Department of Public Health in each province should plan nursing education as carefully as the various provincial departments of education plan general education—*Rae Chittick, R.N.*

Art in a Neuro-Psychiatric Centre

WHERE a set course of formal instruction in an occupational therapy department is not indicated, a program based on guidance, suggestion, and inspiration may prove very satisfactory. Such has been found the case in the art studio of the Sawtelle Veteran's Hospital, Los Angeles, Calif.

With the exception of grilled windows, the art studio gives no indication that it is within the confines of a mental hospital. Music, flowers, and a feeling of informality, lend an air of normalcy to the atmosphere and are most conducive to creative expression and relaxation among the patients.

Execution of the program demands the complete co-operation of the hospital staff. The referral system, practised in the hospital, ensures the utmost in results as any aptitudes are reported on the prescription form; as treatment progresses toward occupational therapy, the prescription form reflects that progress. Treatment aims and occupational interests are carefully set forth, enabling the therapist to schedule a clearly defined program best suited to the patient's needs.

External stimulus is used where poverty of thought or imagination is present. Once a contact with reality has been established, the patient, when he again enters the studio, is eager to complete the project. It is not possible to use living models, and with each patient in a varied state of progress, supplying a model presents a problem. To alleviate this situation, a widely diversified inspirational file is kept, containing coloured, black and white reproductions of several subjects — flowers, animals, landscapes, designs, and architecture. Individual adaptation rather than copying is encouraged, and due to the uninhibitive quality of the work an infinitely varied expression of creativity is manifested.

Psychiatrists, working in close conjunction with the department, have found that certain types of art work are of great value in diagnosis and in checking the patient's progress. In the art studio, all modes of expression are encouraged as a method of projection of the subconscious and the psychiatrist is able to prescribe the type of therapy indicated by the ideas set forth by the patient. Delusional and fantastic work is not fostered beyond the above-mentioned point, and a trend toward reality and concrete objectivity is the goal set for the patients.

The walls are lined with bulletin boards which form a pleasing background for finished work and the display encourages pride in accomplishment. Recently, a great deal of patient interest and enthusiasm was stimulated by participation in a nationwide art exhibit and the four prizes awarded to the work of these patients indicated that the quality of achievement emanating from neuro-psychiatric hospitals need not be delusional and hallucinatory, but can approximate similar work of art and trade schools.

Patients with art school training find that they can, in a measure, continue whatever phase of the work they were engaged in prior to hospitalization. Those who have had no training find it a proving ground for latent talents that can be projected without fear of unkind criticism and ridicule.

Progress is the chief aim of the occupational therapy art program and, working under the aegis of the Medical Rehabilitation Service, it has proved a success for many patients, after leaving the closed wards, are eager to return to the studio for further work. Arrangements are made with the Rehabilitation Service for various tests which enable the hospital to watch the patient progress through pre-vocational work and into the job best suited to him, or, if indicated, to art school. Contacts with discharged patients have proved that the period spent in the art studio was well used and this gratifying knowledge has offered an incentive to venture farther afield in this work.

—Irwin Friedman in American Jr. of Occupational Therapy, courtesy Hospital Abstract Service.

Coming Conventions

Aug. 29—Sept. 2—A.H.A. Institute on Hospital Pharmacy, University of Chicago, Chicago.

Sept. 24-25—American College of Hospital Administrators, Cleveland.

Sept. 26-29—American Hospital Association, Cleveland.

Oct. 1-2—Saskatchewan Conference of the Catholic Hospital Association, Regina.

Oct. 3-8—Western Canada Institute for Administrators, Regina.

Oct. 9—Saskatchewan Hospital Association, Regina.

Oct. 9—Manitoba Conference of the Catholic Hospital Association.

Oct. 10-11—Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.

Oct. 10-14—A.H.A. Institute on Advanced Accounting, Somerset Hotel, Boston.

Oct. 12—Manitoba Women's Hospital Aids Association, Winnipeg.

Oct. 17-21—Inter-American Congress of Surgery, Chicago.

Oct. 17-23—Clinical Congress of the American College of Surgeons, Chicago.

Oct. 24-27—Ambulatory Fracture Association, Royal York Hotel, Toronto.

Oct. 31-Nov. 2—Ontario Hospital Association, Royal York Hotel, Toronto.

Oct. 31-Nov. 2—Canadian Association of Medical Record Librarians, Royal York Hotel, Toronto.

Nov. 2-4—Associated Hospitals of Alberta, Palliser Hotel, Calgary.

Nov. 7-11—A.H.A. Institute for Medical Record Librarians, Buena Vista Hotel, Biloxi, Miss.

Nov. 17-18—B.C. Hospitals Association Convention, Vancouver Hotel, Vancouver.

Nov. 28-Dec. 2—A.H.A. Institute on Hospital Planning, Netherland Plaza Hotel, Cincinnati, Ohio.

Dec. 5-10—A.H.A. Institute on Hospital Personnel Relations, Edgewater Beach Hotel, Chicago.

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Hospital Admissions and Blue Cross

Are there unnecessary admissions to the hospitals? Are patients being kept too long in hospitals? Is the composition of the patient load changing? Opinions differ on the answers to these questions, but the weight of the available evidence indicates a somewhat shortened length of stay in the acute voluntary hospital, and a static or more slowly decreasing length of stay in the public tax-supported institution, attributable to chronic and custodial cases. One of the most frequently-heard criticisms by physicians of Blue Cross and its effect on hospital admissions is that the hospitals admit patients unnecessarily, primarily for diagnostic services, to enable the patient to cash in on his Blue Cross coverage and save the cost of these services were he to secure them as an ambulant patient or in private laboratories and physicians' offices.

Such critics forget several very important facts. The hospital as such admits no private or semi-private patient, except in obvious emergencies, without a physician's referral and only to the care of an individual physician. Similarly, except in most unusual situations, the physician and not the hospital discharges the patient. Thus, if there are unnecessary admissions to hospitals of Blue Cross or other types of private patients, and there probably are, the responsibility is solely the physician's.

Under such circumstances we have heard critical colleagues state, "If I don't admit the case the patient will go to someone else who will, and I will have lost a patient from my practice". Perhaps so, but this argument sounds to us as invalid as it would be if applied to the question of performing an illegal abortion. It seems to us that the mechanisms exist through the medical staff organizations and medical boards of hospitals to control whatever abuses may be occurring, and that the responsibility is theirs and theirs alone. Are we not really criticizing the medical profession itself when we blame unnecessary admissions upon improper performance of the hospital administration and admitting office? Is it not still worse to blame Blue Cross, a fundamentally sound plan which is enabling millions of patients to continue in the hands of their own physicians when hospital care is necessary?

Again, is it sound to blame Blue Cross or the hospital for the greater numbers of diagnostic procedures being performed on hospitalized patients? The physician in charge of the patient—not the hospital or the patient—writes the orders and controls the diagnostic and treatment procedures to be carried out. Very few individuals of private patient calibre are willing to enter a hospital if there is a readier method of achieving the same end. Still fewer consider it pleasant entertainment to be subjected to the physical indignities of a gastro-intestinal series, a barium enema, a glucose tolerance test, or most of the countless other procedures available in hospitals for the advantage of patient and physician. Taking a long range view of the subject, is it not to the advantage of both physician and patient that there are so relatively few restrictions on what services are available to Blue Cross patients? The physician would be more critical than he is and cry regimentation and interference with his professional prerogatives were Blue Cross patients to be further restricted in services available to them through Blue Cross mandate.

Actually, here is an opportunity—and challenge—for the physician himself to play a dominant role in controlling abuses, both on behalf of the plan and the financial operation of the hospital. Special laboratory and diagnostic procedures unwisely or unnecessarily ordered contribute to the hospital's operating costs and the individual physician is at this point in a strategic position to help keep down hospital operating expenses.

On the question of length of stay there appears to be available no completely convincing factual data . . . There are, of course, many contributory factors other than economic ones influencing lengths of stay. Bed shortages have perhaps been the most important, and these have by no means been entirely resolved. Shortened obstetrical periods of hospitalization, early ambulation of surgical cases, the newer regime of antibiotics and chemotherapy have all been contributory. No one can say to what extent such shortening effects may have been offset by the patient's reluctance to leave the hospital because of Blue Cross coverage which by itself might permit him to remain longer without additional out-of-pocket expense.

We as physicians would do well to become better informed on the whole subject of hospital economics, and to take serious stock of our own performance before criticizing Blue Cross or the hospital management for abuses which may be in large part attributable, if they exist, to our own performance.

—Editorial, Westchester Medical Bulletin, March, 1949.

The Best Solution

We are following very closely those areas of the world where plans for medical care and/or hospitalization at government expense have already been put into effect or are under consideration. What the future holds is a matter of conjecture. Those of us who prefer the voluntary system realize as well as any that some relief must be provided especially to those in a low income bracket. We feel, however, that this can best be done, in keeping with our philosophy of private enterprise, by encouraging the growth and expansion of the various prepayment plans, with cost being borne by the individual and where applicable by the employer, and in the case where the individual is unable to pay under the prepayment plan government should bear the cost of the premium. Such a system would still leave an opportunity for donations from individuals and corporations.—*Gilbert Turner, M.D.*

Good Management

Security of the interests of public safety and public health and guarantee of the rights of the sick to uninterrupted, skilful and efficient service are fundamental obligations to which hospital leaders are committed. To the end of fulfilling the demands upon them, hospital administrators and trustees must recognize the inescapable necessity of exploring and exploiting every device of good management.

—Carl I. Flath

Social Security in Europe

At a meeting of representatives of the Research Council for Economic Security, held in Chicago in June, Gerhard Hirschfeld, director of the Council stated: "It is a popular misconception that governments abroad go much farther in providing compulsory social security than government in the United States. But it it true that voluntary social services are much more developed by the communities than is the case in our own country."

In some countries, Denmark, Sweden, Switzerland, and Holland, management in general has been remarkably successful in restraining the blind expansion of compulsory social security; in Great Britain it has utterly failed to cope with the problem.

The cost of compulsory social security abroad is not so high as generally thought. Great Britain and other countries spend about 6 per cent of their national income on social security and an additional 3 or 4 per cent on related matters such as housing, labour markets, and other services. People little realize that many of the social security systems in smaller countries are entirely voluntary.

The idea of the welfare state was not found to be prevalent in Europe. In the opinion of Mr. Hirschfeld, the attitude of people outside of Great Britain was exactly the opposite. "Mostly, they stand proudly on their own resources and on their traditional independence."

The cost of social security is very high in France where the employer pays an average social security tax of 35 per cent of the payroll. In Great Britain, the high cost of social security is held responsible for the fact that the income tax on business establishments averages 45 per cent, where otherwise it might be nearer 35 per cent. In contrast, in smaller countries a business establishment rarely pays more than 10 per cent of payroll for social security.

Mr. Hirschfeld estimated that a system of medical and hospital care in the United States, comparable to that in Great Britain, would require at least 200,000, and possibly as many as 300,000 employees, partly paid and partly voluntary.

Des Visites

(suite de page 42)

(a) Un Comité de représentants des hôpitaux de la région a établi un règlement uniforme.

(b) Ce Comité a obtenu l'appui des corps médicaux et des différents groupements professionnels et des autres services de l'hôpital.

(c) Il a entrepris une campagne de publicité, sérieuse et à répétition, par radio, journaux, publications, affiches.

Le programme uniforme, dépliant très suggestif, a été tiré au cent mille.

Distribués largement aux hospitalisés, à leurs familles et à leurs visiteurs, ces feuillets prônent au malade et en faveur du malade, le repos et la tranquillité dont il a besoin, tout en lui facilitant de raisonnables visites.

Tous ces efforts réunis étant essentiellement subordonnés au bien-être du malade, on en espère beaucoup de fruit.

Conclusion

De cet exposé, il semble que nous pouvons tirer les conclusions suivantes:

1. Il est nécessaire que malades et visiteurs reçoivent dans nos hôpitaux une attention immédiate et se sentent dans un milieu sympathique qui dispose les esprits et les coeurs envers la religion. A nous donc, de réfléter le Christ pour le faire aimer. Si, en tant que religieuses et institutions catholiques, nous diffusons la charité, notre influence rayonnera dans un cercle sans cesse grandissant et s'étendra partout.

2. Pour atteindre cet idéal, nous sentons bien qu'il doit y avoir dans une institution union des personnes, unification des idées, des moyens, des buts, et passion du dévouement. La plus belle vie n'est-elle pas celle où l'on aime passionnément ce que l'on fait? Une puissante sauvegarde, semble-t-il, c'est encore de maintenir dans l'hôpital catholique une telle excellence qu'on n'en saurait trouver motif à l'attaquer et cela pas simplement pour mériter la considération, mais en vue d'assurer le *bien entier* des malades.

3. Si nous ne devons pas craindre d'étendre nos efforts en vue d'augmenter l'influence de l'hôpital catholique, il faut que ce travail s'accomplisse dans une pleine et totale adhésion aux enseignements de la sainte Eglise romaine et pour l'amour de son chef le Christ-Roi Jésus.

New School for X-Ray Technicians

Because of the growing demand for x-ray technicians, four Montreal hospitals, the Children's Memorial Hospital, the Homoeopathic, the Jewish General, and St. Mary's have jointly organized a school to train technicians. Each of these hospitals will nominate two candidates for the course. The candidates will undergo a probationary period of two months, during which time preliminary lectures only will be given. Those who are successful will then start the two-year course, which will cover the curriculum prescribed by the Quebec Society of X-ray Technicians and conforming to the standards of the C.S.R.T. In addition to merely theoretical work, the students will work in the associated hospitals and so become familiar with the hospital procedure.

The Auxiliaries

Busy Workers in Simcoe

The Women's Hospital Aid Association of the Norfolk General Hospital, Simcoe, Ontario, held their annual meeting in June. It was reported that 2,320 articles had been made this year, and that the Nursery Group had made 1,600 items besides. This brought the total to 4,000 articles.

* * * *

Active Groups in St. Thomas

On the occasion of the nurse graduation at the St. Thomas Memorial Hospital tribute was paid to the various women's groups in the area. They were thanked for their assistance in meeting some of the many needs of the hospital and the nursing home, as well as supplying treats for the nurses and patients at Christmas time. Since January of this year, a complete suite of furniture, several easy chairs, and ottomans, and a refrigerator, totalling almost $1,500, had been received from the Aids. Gratitude was expressed to the Kinettes, who have adopted the children's ward and have purchased two new cribs, kindergarden sets, pictures, and drapes. The Pilot Club recently purchased an oxygen tent for the hospital.

* * * *

Movie Benefit at Fort Erie, Ontario

The Women's Auxiliary of the Douglas Memorial Hospital, Fort Erie, Ont., have made and turned in 144 sewn articles. They held a movie benefit night with the all-star girl choir as an added attraction. The women sold 500 tickets and the profits amounted to $126.16.

* * * *

Programs Sold by the Calgary Hospital Aid

Due to the success of the Easter seal campaign, sponsored annually by the Children's Hospital Aid Society of Calgary, funds up to $660 per month will be donated to the Junior Red Cross Crippled Children's Hospital to cover the increased cost of maintaining the Aid's ward. It was reported at their final meeting of the season that the sale of programs at the Horse Show had been very successful, and plans were made to sell programs at the rugby games in the fall.

* * * *

AHA Appoints Staff Member to Aid Women's Auxiliaries

A full-time staff member has joined the American Hospital Association to work with the Committee on Women's Hospital Auxiliaries. The appointment of Mrs. Corena McCallum to serve as secretary of the committee has been announced. She will work with local, state, and regional groups in co-ordinating women's auxiliary activities. Her initial job with the Association will be to assist in planning for the second conference on Women's Hospital Auxiliaries to be held in Cleveland from September 26 to 29 in conjunction with the convention of the American Hospital Association.

Neil B. McGillivray, M.D.

Dr. Neil B. McGillivray, 38, died suddenly on June 27 at his home in Toronto. He was a graduate of the University of Toronto, Class of '25, and interned in the Toronto General Hospital. Dr. McGillivray spent some time in post graduate study in England, where he was elected a member of the Royal College of Physicians. He was also a fellow of the Royal College of Physicians in Canada. At the time of his death, Dr. McGillivray was chief of the medical staff of Wellesley Division, Toronto General Hospital.

Nellie Gorgas, F.A.C.H.A.

The many friends in Canada of Nellie Gorgas, F.A.C.H.A., will regret exceedingly her sudden passing on June 4th. Miss Gorgas, who was administrator of St. Barnabas Hospital, Minneapolis, and a regent of the American College of Hospital Administrators, was a popular speaker at conventions and institutes and had spoken on many occasions at Canadian meetings. She was particularly well known to Manitobans and recently had been honoured by the city of Winnipeg for her assistance to Manitoba hospitals.

Miss Gorgas was the first president of the Upper Midwest Hospital Association, a former president of the Minnesota Hospital Association, and had served on the A.H.A. Council on Administrative Practice, as well as on the Minneapolis and Twin City Councils. She was a graduate of the course in hospital administration at the University of Chicago and was past president of the course's graduate group. The Alumni Association of that University had conferred on her the "Alumni Citation of Useful Citizen". The hospital field has lost a real leader.

Tbc. Surveys Organized In Alberta and N.W.T.

Several thousand Indians and white people in outlying sections of Alberta, the Yukon and the North West Territories, are being x-rayed for tuberculosis as part of a continuing drive for the detection and elimination of this disease. During July surveys were scheduled for the Hobbema Indian agency and for the Saddle Lake agency in Eastern Alberta. A second x-ray unit will go up the Alaska Highway as far as it goes into the Yukon Territory. Arrangements have been made for moving the x-ray equipment by boat along the Yukon River and by air to Dawson City and Mayo Landing. A third x-ray unit will go to the Great Slave Lake area to x-ray all the Indians in the Fort Resolution agency and the entire population of the Yellowknife Settlement. Mass surveys on the Sarcee reserve and on the Blood reserve at Cardston have already been completed. Every effort will be made to provide early and effective treatment for all cases of tuberculosis discovered by the mass surveys.

Human will need only to will more strongly than fate, and she is fate. —*Thomas Mann.*

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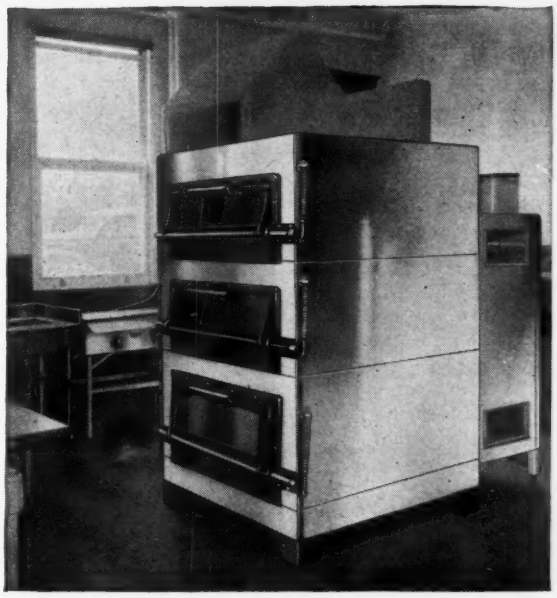

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To What Extent Should Governments Do More?

There is a great need for publicity in the daily press regarding the hospital problem. The public should have the facts placed before them in order that an informal opinion should emerge as to how far the matter should be left to the State without running the risk of enforced alteration of those medical and hospital procedures that over the years of freedom in the exercise of individual initiative have proved beneficial to mankind.

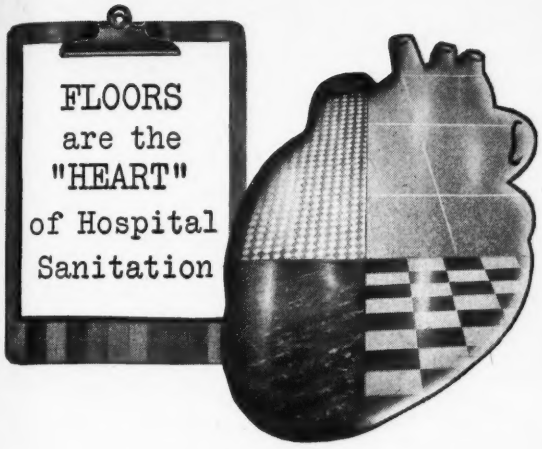
In your various welfare activities, you have, undoubtedly, encountered a wide divergence of opinion as to where the limits of responsibility for community health and welfare should be fixed under a democratic system such as ours.

You have, perhaps, found yourself in agreement with the thought, often expressed, that government should do more. This is true especially in regard to the costs of indigent care. Until those costs are more adequately borne by the public authorities, projects for the building of new hospitals with public funds, laudable as many of them appear to be, should be carefully considered, if after completion there is to result a further drain on private resources in order to meet more operating and maintenance deficits. There is, of course, a need for reconstruction and improvement of present facilities for which, as yet, no public funds have been authorized despite the fact that such expenditures would not only meet the rapidly increasing requirements of modern medicine and research but they would accomplish greater efficiency and a consequent saving in the expenditures of existing hospitals.

People are more health conscious than ever before and are prone to encourage greater expenditure of public funds in this field. But we must not forget that in a democratic society, there is a danger of abandoning our social welfare activities to the control of government. It is not easy to contemplate a system based upon paternalism resulting from the elimination of that social consciousness which has stimulated individuals, singly and in groups, to assume some responsibility for the welfare of their fellow beings.

Public expenditures are made largely out of taxes collected from the people. Once the tax is paid most individuals have little interest in how it is spent. But when they do their own spending by means of contribution to some welfare activity of the community, their interest in that activity continues to their personal satisfaction and to the benefit of the community. To shift the burden to the State is to help hasten the arrival of a change that may bring far reaching and unfavourable results to the individual and the system under which he lives. There are consequently grounds for the belief that both public and private support must be available. There is a place for each if health and welfare are to be protected, although it is to be remembered that as the State increases its share, the burden of increased taxation may restrict the ability of the individual in the field of philanthropy.

—J. A. Eccles, President, Royal Victoria Hospital, Montreal, in the 1948 Annual Report.



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3. CORO-NOLEUM *Disinfects and Deodorizes as it Cleans* all floors except rubber, soft mastic, or asphalt base tile.	Phenol coefficient of 7.5. Helps kill many germs and aids in the protection of Health. Ideal for operating rooms, washrooms and special wards. Economical to use.
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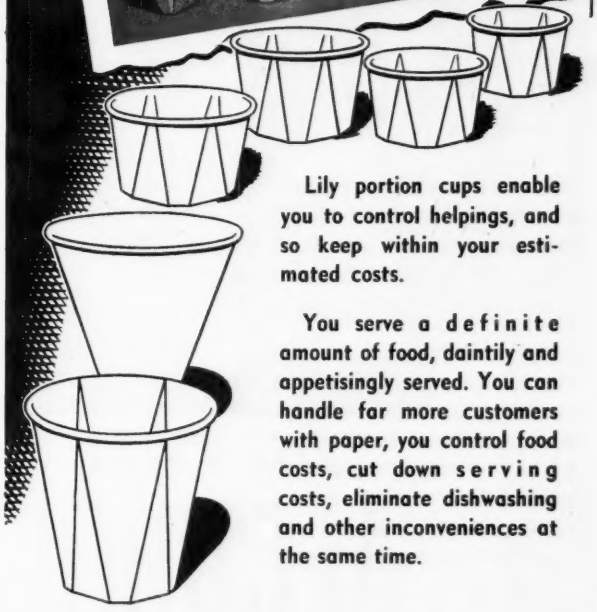

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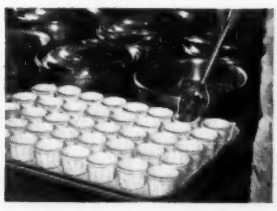

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Radio Programs at Mountain Sanatorium

(From the report of the Radio Program Director, Sylvia James, in the 1948 Annual Report of Mountain Sanatorium, Hamilton, Ont.)

The work of the radio department is included in that of the educational department, daily lessons being given over the air by the teaching staff. Subjects taught by the radio director are the Department of Education music course, grades IX and X, and a radio course patterned on Queen's University Summer Radio Institute and on that of the Central Technical School, Toronto. This course includes radio speech, script-writing, production, and directing. Scripts for all music programs, plays, talks, stories, book reviews, and local news, given from the studio, are prepared, and as far as possible, presented by patients.

For recreation, the sanatorium radio brings to its listeners network news, music talks, soap serials, and the most popular evening programs, all planned from surveys. The sanatorium studio also provides singers, choirs, quiz shows, and special speakers. By the use of a new portable microphone programs may now be given directly from the wards. This enables bed patients, as well as those on exercise, to contribute their talents to the radio department. Other items of interest to patients are (a) weekly talks by the medical superintendent and by one of the chaplains, (b) the medical question box, conducted by one of the doctors, and (c) church services arranged by the chaplains.

Radio is the main link between the sanatorium community and the outside world. By a direct line, McMaster University sends out weekly programs, both musical and educational, to sanatorium listeners. Also, the university makes available to the radio department free use of its very fine record library. Other outside contacts are made through programs and speakers provided by private citizens and various organizations. Among the latter are local radio stations, the C.B.C., local public speaking groups, the Red Cross, many churches, and both civil and military bands. Through these contacts, many generous donations of money, books, and recordings, have been received.

Thus in many ways, the department contributes toward the rehabilitation of patients, both while they are in sanatorium and after discharge. Last year, through experience and training gained in the studio, a former patient obtained a position as script-writer and announcer in a recognized radio station. The scope of the department's work is made possible through the help of a full-time assistant.

Too Much Detail Under British System

The Department of Health in Scotland is unpopular with hospital staff by reason of the mass of trivial data which is sought. One such required report—the use of vegetables from hospital gardens—was regarded by East Fife Hospitals Board as ridiculous. Their matrons had much more important work to do than make such returns, it was decided, and objection is being lodged against the imposition of such duties.—*Hospital and Health Management, June, 1949.*

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For greater convenience and economy, both important considerations, Streptomycin Calcium Chloride Complex is supplied in a multiple-dose container, 5 Gm. in a 50 cc. vial.

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15.5 cc.	60 mg.	35.5 cc.	125 mg.
9 cc.	100 mg.	28.5 cc.	150 mg.
7 cc.	125 mg.	20.5 cc.	200 mg.
5.5 cc.	150 mg.	15.5 cc.	250 mg.
4.5 cc.	185 mg.	12 cc.	300 mg.
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A.C.S. and Inter-American Congress of Surgery Meet Jointly

The Clinical Congress of the American College of Surgeons, always international in scope, will be exceptionally world-wide in character when it convenes in Chicago from October 17 to 23 because it will include the Sixth Inter-American Congress of Surgery. Also many delegates from the 13th Congress of the International Society of Surgery, which meets in New Orleans the previous week, are planning to attend the Chicago Congresses.

Television of operations in color from St. Luke's Hospital will be a feature of each day's program during the Clinical Congress. The other events will include scientific sessions, official meetings, hospital conferences, medical motion picture showings, technical and scientific exhibitions, and visits to operative and non-operative clinics in 24 hospitals in the Chicago area.

This will be the first time that the Inter-American Congress of Surgery has been held in the United States. Previous Congresses have all been held in South America. It is expected that there will be about 300 surgeons from South America attending the congress in Chicago.

Is it Shortage of Doctors or Poor Distribution?

"It seems to be popular now to decry the shortage of physicians. Mr. Oscar R. Ewing has told us that we have a shortage and that the Government must produce 22,000 more than the present production rate within the next ten years, in order to supply the needs of the country. . .

" . . . We will admit some areas do not have enough doctors, but some areas have too many. Therefore the apparent shortage is only poor distribution. The medical profession has been trying for some years to induce doctors to go into rural areas and loan funds have been established to help students with that ambition. Our Michigan Foundation for Medical and Health Education established a fund for that purpose two years ago and to date has had no applications! There have been six inquiries for information. Incidentally, the University of Michigan has an unrestricted loan fund of $60,000 for students in the medical department which could be used for training students in rural areas; the whole University has approximately $300,000 in loan funds and *no takers.* Students today want scholarships, not loan funds. Rural doctors must have adequate workshops.

"We believe the problem in this matter of shortage of doctors is not in educating more doctors. We think too many of our doctors are difficult to find during certain hours and too many have adopted rigid appointment schedules of practice. That is the worst complaint that we are hearing from the public and if that could be corrected, we would hear no more complaint of lack of doctors."

—Editorial, J. of the Michigan State Medical Society, Feb., 1949.

I have the feeling that once I am at home again I shall need to sleep three weeks on end to get rested from the rest I've had!—*Thomas Mann.*

Provincial Notes

(Concluded from page 54)

fire marshal's office was read. The report set forth a list of 25 improvements which must be made to make the hospital safe. It is estimated that these changes would cost about $200,000.

* * * *

WESTON. Construction of the Humber Memorial Hospital has begun. This hospital of new-type design will cost $425,000 and will have a capacity of 52 beds, which represents a 30 per cent increase over the building originally planned. Land is available around the hospital, so further expansion will be possible.

Quebec

MONTREAL. A group of experts in hospital administration and construction have made a 15-day study of conditions at Notre Dame Hospital. They reported that the hospital needed 375 more beds. They found the administrative departments and the clinical services of the hospital in need of expansion also. The laboratories and the electroradiological services, in particular, had been forced into a space so small that they could no longer handle the daily demand.

Prince Edward Island

SUMMERSIDE. Construction work on the new Prince County Hospital has started again. This building was started two years ago, but work was discontinued because of insufficient funds. The plans have since been revised, and now provide for a building which will cost between $600,000 and $700,000. The building will be T-shaped and will consist of four floors including the basement. It will have a capacity of 125 beds, which can be increased in an emergency to 146.

Ten Ways To Kill An Association

1. Don't come to the meetings.
2. If you do, come late.
3. If the weather doesn't suit you, don't think of coming.
4. If you do not attend a meeting, find fault with the officers and members.
5. Never accept an office, as it is easier to criticize than do things.
6. Nevertheless, get annoyed if you are not appointed to a committee. If you are appointed, don't attend the committee meetings.
7. If asked by the Chairman to give your opinion regarding some important matter, tell him you have nothing to say. After the meeting, tell everyone how things should have been done.
8. Do nothing more than is absolutely necessary. When other members roll up their sleeves and unselfishly use their ability to help things along, howl that the Association is run by a "clique".
9. Hold back your dues as long as possible—better still, don't pay at all.
10. Don't bother about getting new members, but if you do, be sure they are grouches like yourself. — *Age Publications Ltd., Toronto.*

Administrative Procedures

(Concluded from page 31)

accommodation are, of course, treated on a chargeable basis.

Hospital By-laws

Turning to the broader aspects of administration, it is recommended that each hospital, regardless of size, should have hospital by-laws. Medical staff by-laws, too, would be of great assistance to the administrator. These must be accepted in full by the attending medical staff and no changes should be effected without the approval of the medical staff. Provincial departments of public health and the Canadian Hospital Council are in a position to assist any hospital to prepare such by-laws.

Staff conferences composed of the medical staff, director of nurses, and administrator, are essential to the efficient operation of the hospital and to a mutual understanding of the problems encountered. Full discussion of these problems lends itself to early and satisfactory solution.

Hospitals in Britain

(Concluded from page 48)

is much the most expensive. It ought to be reserved for patients who cannot be properly treated in any other way. It is conceivable that in the long run every pound spent on home nurses, midwives, general practitioners, and health centres for the better equipment of the front-line medical team, would be worth as much to the community as two pounds spent on the in-patient facilities of the hospitals."

Laboratory Technologists

(Concluded from page 56)

neatness, co-operative spirit, habits, scientific interest, and other personal characteristics of the student. Such records shall be readily available to the Committee on Approval.

11. Tuition fees charged shall not be exorbitant.

12. The hospital laboratories approved for training of technologists shall not allow any "students", volunteer workers, or so-called "technician interns" to serve in the laboratory as substitutes for salaried qualified workers in return for obtaining training and experience in laboratory technique.

13. The recognition of commercial laboratories is not favourably considered by the Committee. Commercial advertising is considered unethical.

Health Conditions in Israel

The appearance of Volume 1, 1949, of the *Hebrew Medical Journal*, initiates the 22nd year of publication of this bilingual, semi-annual Journal. In this issue, a number of features dealing with the present health conditions in Israel are presented. Included are articles on infectious diseases in that section, on the prevalence of tuberculosis among the Jews in Israel as compared with the prevalence elsewhere, and one article describing dental health in that area.

Experience is the name everyone gives to his mistakes.—*Oscar Wilde.*

Chances of Living Going Up

Three-quarters of all the babies born last year will live to the age of 60 and one-half of them will be alive at the age of 72, even if there is no further improvement in the mortality rate. This is in marked contrast with the beginning of the century when, under the then prevailing mortality conditions, only three-quarters of those born at that time would live to the age of 24, and one-half would be alive at the age of 58.

This change in health environment has been reported by Reinhard A. Hohaus, actuary, Metropolitan Life Insurance Company in an editorial appearing in the *Wisconsin State Medical Journal.*

A major factor in the greatly increased length of the average life span has been the control of infectious and acute diseases, notably those of childhood.

"At the beginning of the century", Mr. Hohaus stated, "diarrhoea and enteritis along with the principal communicable diseases of childhood—scarlet fever, whooping cough, diphtheria, and measles—accounted for over 10 per cent of all deaths. Today, they account for less than one per cent of the total. The death rate for tuberculosis in 1947 was 33.5 per 100,000 population, only one-sixth of the rate for 1900. In the last decade alone, mortality from pneumonia has been cut in half due largely to the sulpha drugs and penicillin. Maternal mortality has been cut by three-fourths during the last 20 years and infant mortality by half within the same period.

"Under the mortality situation at the turn of the century, about one-third of those born would eventually have died because of some acute disease, but under current conditions the chance is less than one in ten."

The trend toward greater longevity can be ascribed to many developments, among which are:

1. The achievements of intensive research in medical and allied sciences, and the ready application of new discoveries and improved diagnostic and therapeutic methods by medical practitioners.

2. The growth of public health services at the various levels of government.

3. The widespread activities of non-governmental health and welfare agencies.

4. The far-reaching effect of higher living standards made possible by the nation's economic progress.

Male Nurses—
Neglected Source of Supply

The great need is not in the education of men as nurses but the education of the public to accept men if we train them. There are few positions in which a man nurse will not serve as well as a woman; there are some in which he is superior. Yet because of the ancient weight of tradition, the public has been brought to believe that men are unseemly in our profession. Until this tradition is overthrown it would be sheer exploitation to recruit men nurses on a large scale. But until they are so recruited this country will not have the great numbers of nurses it will need next year and in the years to come; and a great injustice to men, to our profession, and to all who need nursing will not be corrected.—*Mabel Detmold, "Modern Hospital", Sept., 1948.*